103D CONGRESS
1ST SESSION

S. 1600

To amend the Social Security Act to establish long-term care assistance programs for the elderly, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 28 (legislative day, OCTOBER 13), 1993

Mr. PACKWOOD (for himself, Mr. DOLE, Mr. SIMPSON, and Mr. DURENBERGER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act to establish long-term care assistance programs for the elderly, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Secure Choice Act of 1993".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

TITLE I—LONG-TERM CARE PROVISIONS

SEC. 101. LONG-TERM CARE ASSISTANCE PROGRAMS ESTABLISHED.

(a) IN GENERAL.—The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

"TITLE XXI—LONG-TERM CARE ASSISTANCE PROGRAMS

"TABLE OF CONTENTS OF TITLE

"Part A—Grants to States for Long-Term Care Assistance Programs

"appropriation

"Sec. 2101. (a) In General.—For the purpose of enabling each State to—

"(1) furnish long-term care assistance to any functionally impaired individual, severely functionally impaired individual, or functionally impaired child under this part; and

"(2) establish a Secure Choice Insurance Program under part B;

there is hereby authorized to be appropriated and is appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

"(b) LIMITATION ON FEDERAL EXPENDITURES FOR LONG-TERM CARE ASSISTANCE.—

"(1) IN GENERAL.—The total amount of payments made by the Federal Government under this part for a fiscal year shall not exceed the sum of the allotments for all States determined under paragraph (2).

"(2) STATE ALLOTMENTS.—The Secretary shall determine an allotment for each State for each fiscal year equal to the sum of the State's allotments for all applicable age groups determined under paragraph (3).

"(3) STATE ALLOTMENTS BY APPLICABLE AGE GROUP.—The Secretary shall determine a State allotment for each applicable age group in accordance with the following formula:

$$\text{State allotment for applicable age group} = \left[\text{applicable actual percentage} \left(\text{adjusted actual per capita amount for the age group} \right) + \text{applicable median percentage} \left(\text{adjusted median per capita amount for the age group} \right) \right] \times \text{number of countable individuals in the age group}$$

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) APPLICABLE AGE GROUP.—The term 'applicable age group' means any of the following age groups:

"(i) Individuals who have not attained 65 years of age.

"(ii) Individuals who have attained at least 65 years of age but have not attained 75 years of age.

"(iii) Individuals who have attained at least 75 years of age but have not attained 85 years of age.

"(iv) Individuals who have attained at least 85 years of age.

"(B) APPLICABLE ACTUAL PERCENTAGE.—The term 'applicable actual percentage' means—

"(i) for fiscal year 1995, 90 percent; and

"(ii) for each succeeding fiscal year, the percentage determined under this subparagraph for the preceding fiscal year reduced by 10 percent, but not less than 0 percent.

"(C) APPLICABLE MEDIAN PERCENTAGE.—The term 'applicable median percentage' means—

"(i) for fiscal year 1995, 10 percent; and

"(ii) for each succeeding fiscal year, the percentage determined under this subparagraph for the preceding fiscal year increased by 10 percent, but not greater than 100 percent.

"(D) ADJUSTED ACTUAL PER CAPITA AMOUNT.—

"(i) IN GENERAL.—The term 'adjusted actual per capita amount' for an applicable age group means—

"(I) for fiscal year 1995, an amount equal to the unadjusted actual per capita amount (as determined under clause (ii)) for the age group updated by the inflation percentage (as determined under clause (iii)); and

"(II) for fiscal year 1996 and succeeding fiscal years, an amount equal to the amount determined under this subparagraph for the age group

for the previous fiscal year updated by the inflation percentage.

"(ii) UNADJUSTED ACTUAL PER CAPITA AMOUNT.—

"(I) IN GENERAL.—The unadjusted actual per capita amount determined under this clause for an applicable age group is an amount equal to the quotient of—

"(aa) the total Federal payment made to the State under section 1903 for long-term care services (as defined in subclause (II)) furnished to individuals in the applicable age group for fiscal year 1994, divided by

"(bb) the total number of individuals in such applicable age group who had incomes below the income official poverty line (as defined in section 2115(f)) during fiscal year 1994.

"(II) LONG-TERM CARE SERVICES.—For purposes of subclause (I),

the term 'long-term care services' means—

"(aa) nursing facility services (as defined in section 1905(f));

"(bb) home or community-based services furnished under a waiver under subsection (c) or (d) of section 1915;

"(cc) home and community care furnished under section 1929;

"(dd) home health care services (as referred to in section 1905(a)(7));

"(ee) personal care services (as described in section 1905(a)(24)); and

"(ff) private duty nursing services (as referred to in section 1905(a)(8)).

"(iii) INFLATION PERCENTAGE.—The inflation percentage determined under this clause is equal to—

"(I) the percentage change in the long-term care inflation index (as defined in subparagraph (G)) for the fiscal year; or

"(II) if the long-term care inflation index has not been developed, 5 percent.

"(E) ADJUSTED MEDIAN PER CAPITA AMOUNT.—

"(i) IN GENERAL.—The term 'adjusted median per capita amount' for an applicable age group means—

"(I) for fiscal year 1995, an amount equal to the unadjusted median per capita amount (as determined under clause (ii)) for the age group updated by the inflation percentage (as determined under subparagraph (D)(iii)); and

"(II) for fiscal year 1996 and succeeding fiscal years, an amount equal to the amount determined under this subparagraph for the age group for the previous fiscal year updated by the inflation percentage.

"(ii) UNADJUSTED MEDIAN PER CAPITA AMOUNT.—The unadjusted median per capita amount determined under this clause for an applicable age group is an amount equal to the median of the unadjusted actual per capita amounts (determined under subparagraph (D)(ii)) for all States for such age group.

"(F) COUNTABLE INDIVIDUALS.—The term 'number of countable individuals' for an applicable age group means the number of individuals in the State who are in the age group who have incomes below the income official poverty line during the fiscal year.

"(G) LONG-TERM CARE INFLATION INDEX.—The term 'long-term care inflation index' means an inflation index developed by the Secretary which is based on the growth in the average annual total wages of individuals—

"(i) who are employed by nursing facilities or home health agencies, and

"(ii) who are nurses, personal care attendants, or other individuals providing long-term care services under this part.

"(c) LIMITATION ON STATE OBLIGATION TO MAKE EXPENDITURES.—A State shall not be obligated to make expenditures under this part in excess of the amount of expenditures necessary for such State to receive payments from the Federal Government under this part equal to the amount of such State's allotment determined under subsection (b)(2).

"STATE PLANS FOR LONG-TERM CARE ASSISTANCE

"SEC. 2102. (a) STATE PLAN REQUIREMENTS.—A State plan for long-term care assistance must meet the following requirements:

"(1) ADMINISTRATION OF THE STATE PLAN.—The State plan must—

"(A) provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan;

"(B) provide that the plan shall be in effect in all political subdivisions of the State;

"(C) provide—

"(i) such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan; and

"(ii) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds

under the State plan, each individual who formerly was such an officer or employee and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the Federal Government, by an officer or employee of the Federal Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code;

"(D) provide for financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan with respect to which payments under section 2103 are authorized by this part and provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the

amount, duration, scope, or quality of care and services available under the plan;

"(E) provide that all individuals wishing to make application for long-term care assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

"(F) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for long-term care assistance under the plan is denied or is not acted upon with reasonable promptness;

"(G) provide that the State will have in effect an appropriate appeals process for determinations under the comprehensive functional assessment (as defined in section 2115(b)) and the individual community care plan (as defined in section 2115(g)) established for such individuals; and

"(H) provide that the State health agency, or other appropriate State agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining standards for private or public entities

from which recipients of long-term care assistance under the plan may receive care or services.

"(2) INDIVIDUALS ELIGIBLE FOR ASSISTANCE.—The State plan must provide—

"(A)(i) for making long-term care assistance available, including at least the care and services described in subparagraphs (A) and (C) of section 2115(h)(1), to functionally impaired individuals described in section 2115(d)(1) who meet the income and resource eligibility requirements of paragraphs (1) and (2) of subsection (f);

"(ii) for making long-term care assistance available, including at least the care and services described in subparagraphs (A), (B), and (C) of section 2115(h)(1), to severely functionally impaired individuals described in section 2115(d)(2) who meet the income and resource eligibility requirements of paragraphs (1) and (2) subsection (f); or

"(iii) for making long-term care assistance available, including at least the care and services described in subparagraphs (A), (B), and (C) of section 2115(h)(1), to functionally im-

paired children described in section 2115(d)(3) who meet the income and resource eligibility requirements of paragraphs (1) and (2) subsection (f);

"(B) that the long-term care assistance made available to any individual described in subparagraph (A) shall not be less in amount, duration, or scope than the long-term care assistance made available to any other such individual; and

"(C) for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions conforming to such regulations with respect to the furnishing of long-term care assistance under the plan to individuals who are residents of the State but are absent from the State.

"(3) STANDARDS FOR ELIGIBILITY.—

"(A) IN GENERAL.—The State plan must provide for reasonable standards which shall be comparable for all individuals for determining eligibility for and the extent of long-term care assistance under the plan which—

"(i) are consistent with the objectives of this part;

"(ii) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient;

"(iii) provide for reasonable evaluation of any such income or resources;

"(iv) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21; and

"(v) at the option of the State provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, necessary expenditures incurred by an individual for medical care that are not reimbursable by any other payor.

"(B) INFORMATION REGARDING INCOME AND ELIGIBILITY VERIFICATION.—The State plan must provide that information is requested and exchanged for purposes of income and eligi-

bility verification in accordance with a State system which meets the requirements of section 1137.

"(C) POST-ELIGIBILITY APPLICATION OF INCOME TO COST OF CARE AND PERSONAL NEEDS ALLOWANCES.—The State plan must comply with the provisions of subsection (g) with respect to the application of an individual's income to the cost of care and personal needs allowances.

"(D) TRANSFER OF ASSETS, TRUSTS, LIENS, AND ADJUSTMENTS AND RECOVERIES.—The State plan must comply with the provisions of section 2112 with respect to transfers of assets, trusts, liens, and adjustments and recoveries.

"(E) COMMUNITY SPOUSES.—The State plan must meet the requirements of section 2114 with respect to protection of community spouses.

"(4) QUALITY OF CARE FURNISHED UNDER THE PLAN.—

"(A) BEST INTERESTS OF RECIPIENTS.—The State plan must provide such safeguards as may be necessary to assure that eligibility for

care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.

"(B) EVALUATIONS OF INDIVIDUALS RECEIVING CARE.—The State plan must provide that in each case for which payment is made for services under the State plan—

"(i) the individual who receives such services has received a comprehensive functional assessment under which a qualified community care case manager, in consultation with an individual's primary medical care provider, determines that the individual is a functionally impaired individual, a severely functionally impaired individual, or a functionally impaired child; and

"(ii) in the case of payment for home and community based services, such services were furnished under a written plan of care established and periodically reviewed and evaluated by a qualified community care case manager.

"(C) COMMUNITY CARE CASE MANAGERS.—The State plan must provide that any contract with a qualified community care case manager to provide case management services shall include a provision under which such case manager agrees not to provide long-term care services to any individual for whom the case manager provides case management services.

"(D) APPROPRIATENESS AND QUALITY OF CARE.—The State plan must provide—

"(i) that the State health agency, or other appropriate State agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional personnel of the appropriateness and quality of care and services furnished to recipients of long-term care assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency; and

"(ii) that, except as provided in section 1919(g), the State or local agency utilized by the Secretary for the purpose spec-

ified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this part the function of determining whether institutions and other long-term care providers meet the requirements for participation under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation.

"(E) DESCRIPTIONS OF METHODS USED TO ASSURE QUALITY.—The State plan must include descriptions of—

"(i) the kinds and numbers of professional personnel and supporting staff that will be used in the administration of the

plan and of the responsibilities they will have;

"(ii) the standards, for private or public entities from which recipients of long-term care assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards;

"(iii) the cooperative arrangements with State health agencies entered into with a view to appropriate utilization of and maximum coordination of the provision of long-term care assistance with the services administered or supervised by such agencies; and

"(iv) other standards and methods that the State will use to assure that care and services provided to recipients of long-term care assistance are of high quality.

"(5) NURSING FACILITIES.—The State plan must provide—

"(A) that any nursing facility receiving payments under such plan must satisfy all the

requirements of subsections (b) through (d) of section 1919 as they apply to such facilities;

"(B) for including in 'nursing facility services' at least the items and services specified (or deemed to be specified) by the Secretary under section 1919(f)(7) and making available upon request a description of the items and services so included;

"(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this part; and

"(D) for compliance (by the date specified in the respective sections) with the requirements of—

"(i) section 1919(e) (relating to State requirements for nursing facilities);

"(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

"(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies).

"(6) FREEDOM OF CHOICE OF PROVIDER.—Except as provided in section 2110 and except in the

case of Puerto Rico, the Virgin Islands, and Guam, the State plan must provide that any individual eligible for long-term care assistance may obtain such assistance from any institution, agency, or person, qualified to perform the services required, who undertakes to provide the individual with such services.

"(7) AGREEMENTS WITH PROVIDERS AND PAYMENT FOR SERVICES.—

"(A) AGREEMENTS.—The State plan must provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees—

"(i) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving long-term care assistance under the State plan; and

"(ii) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

"(B) DEDUCTIBLE, COST SHARING, AND SIMILAR CHARGES.—The State plan must provide that deductible, cost sharing, and similar charges may be imposed only as provided in section 2111.

"(C) PAYMENTS UNDER THE PLAN.—

"(i) PAYMENTS TO NURSING FACILITIES.—The State plan must provide for payment (except where the State agency is subject to an adjustment under section 2109) for nursing facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which take into account the costs (including the costs of services required to attain or maintain the physical, mental, and psychosocial well-being of each resident eligible for benefits under this part) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower

costs (if any) of the facility for nursing care and which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable Federal and State laws, regulations, and quality and safety standards and to assure that individuals eligible for long-term care assistance have reasonable access (taking into account geographic location and reasonable travel time) to nursing facility services of adequate quality.

"(ii) VALUATION OF CAPITAL ASSETS.—The State plan shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

"(I) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year; or

"(II) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average).

"(iii) PAYMENT FOR HOME AND COMMUNITY BASED SERVICES.—The State plan shall provide for payment for home and community based services through rates established by the State in conformance with applicable Federal and State laws, regulations, and quality and safety standards.

"(D) CLAIMS PAYMENT PROCEDURES.—The State plan must provide for claims payment procedures which—

"(i) ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan are paid within 30 days after the date of receipt of such claims and that 99 percent of such claims are paid within 60 days after the date of receipt of such claims; and

"(ii) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

"(E) CONSULTATIVE SERVICES.—The State plan must provide for consultative services by health agencies and other appropriate agencies of the State to nursing facilities and such other long-term care providers as the Secretary may specify in order to assist them—

"(i) to qualify for payments under this part;

"(ii) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this part; and

"(iii) to provide information needed to determine payments due under this part on account of care and services furnished to individuals.

"(F) METHODS AND PROCEDURES RELATING TO UTILIZATION AND PAYMENT.—The State plan must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

"(G) DISCLOSING ENTITIES.—The State plan must provide that any disclosing entity (as defined in section 1124(a)(2)) receiving pay-

ments under such plan complies with the requirements of section 1124.

"(H) EXCLUSION OF CERTAIN INDIVIDUALS OR ENTITIES.—The State plan must provide that the State agency shall exclude any specified individual or entity from participation under the State plan for the period specified by the Secretary, when required by the Secretary to do so pursuant to section 1128 or 1128A or title XVIII, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period.

"(I) AUDITING OF RECORDS.—The State plan must provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to ensure that proper payments are made under the plan.

"(8) THIRD PARTY LIABILITY.—The State plan must provide—

"(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third par-

ties (including entities providing for health or long-term care insurance) to pay for care and services available under the plan, including—

"(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for long-term care assistance; and

"(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall—

"(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 2103(h), and

"(II) be subject to the provisions of section 2103(h)(4) relating to reductions in Federal payments for failure to meet conditions of approval;

"(B) that in any case where such a legal liability is found to exist after long-term care assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

"(C) that in the case of an individual who is entitled to long-term care assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service—

"(i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 2111); or

"(ii) in an amount which exceeds the lesser of (I) the amount which may be col-

lected under section 2111, or (II) the amount by which the amount payable for that service under the plan (disregarding section 2111) exceeds the total of the amount of the liabilities of third parties for that service; and

"(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service.

"(9) ASSIGNMENT.—The State plan must provide for mandatory assignment of rights of payment for long-term care services owed to recipients, in accordance with section 2107.

"(10) INFORMATION REQUIREMENTS.—

"(A) REQUIREMENTS ON STATE.—The State plan must provide—

"(i) that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from

time to time find necessary to assure the correctness and verification of such reports;

"(ii) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

"(iii) that within 90 days following the completion of each survey of any facility or other provider of long-term care services by the appropriate State agency, such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such facility or other provider with (I) the statutory conditions of participation imposed under this part, and (II) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility or other provider;

"(iv) that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action;

"(v) a method of making information evidencing eligibility for long-term care assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address; and

"(vi) that the State will provide information and access to certain information respecting sanctions taken against practitioners and providers by State licensing authorities in accordance with section 1921.

"(B) REQUIREMENTS ON PROVIDERS.—The State plan must—

"(i) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, services under the plan, shall supply (within such period as

may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1128(b)(9);

"(ii) require each facility or other provider of long-term care services which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system for that type of facility or provider; and

"(iii) provide for filing of uniform cost reports by each nursing facility and periodic audits by the State of such reports.

"(b) CONDITIONS OF APPROVAL OF PLAN.—The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that the Secretary shall not approve any plan which imposes, as a condition of eligibility for long-term care assistance under the plan—

"(1) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

"(2) any citizenship requirement which excludes any citizen of the United States.

"(c) SANCTION.—In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to 3 times the amount of any payment sought to be collected by that person in violation of subsection (a)(8)(C).

"(d) LIMITED WAIVER OF REQUIREMENTS.—Notwithstanding any other requirement of this part, the Secretary may waive or modify any requirement of this part with respect to the long-term care assistance program in American Samoa and the Northern Mariana Islands, other than—

"(1) a waiver of the Federal long-term care assistance percentage;

"(2) the limitation in section 1108(c), or

"(3) the requirement that payment may be made for long-term care assistance only with respect to amounts expended by American Samoa or the

Northern Mariana Islands for care and services described in subparagraphs (A) through (D) of section 2115(h)(1).

"(e) WAIVER RELATING TO CLAIMS PROCEDURE.—The requirement of subsection (a)(7)(D) with respect to a State plan may be waived by the Secretary if the Secretary finds that the State has exercised good faith in trying to meet such requirement.

"(f) INCOME AND RESOURCE REQUIREMENTS FOR ELIGIBILITY DETERMINATIONS.—

"(1) INCOME REQUIREMENT.—An individual meets the income requirement of this subsection if—

"(A) the amount of the individual's monthly income, less

"(B) the amount of the individual's incurred costs for long-term care services for the month that are not reimbursed by a third party,

does not exceed 100 percent of the income official poverty line (as defined in section 2115(f)).

"(2) RESOURCE REQUIREMENT.—An individual meets the resource requirement of this subsection if the individual's resources do not exceed—

"(A) $2,000 for individuals receiving long-term care assistance in a nursing facility; and

"(B) $5,000 for individuals receiving long-term care assistance in a setting other than a nursing facility.

"(3) ROUNDING.—The total amount of the income limitation determined under paragraph (1) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

"(4) DEFINITIONS.—Except as otherwise provided, for purposes of this part, the term 'income' has the meaning given such term in section 1612 and the term 'resources' has the meaning given such term in section 1613.

"(g) POST-ELIGIBILITY APPLICATION OF INCOME TO COST OF CARE AND PERSONAL NEEDS ALLOWANCES.—

"(1) IN GENERAL.—Each individual receiving long-term care assistance under this part shall contribute an amount equal to the amount determined under paragraph (2) to the cost of the long-term care services furnished to such individual under this part.

"(2) AMOUNT OF CONTRIBUTION.—

"(A) IN GENERAL.—With respect to an individual, the amount determined under this

paragraph is an amount equal to such individual's post-eligibility monthly income (as defined in paragraph (3)) less the applicable personal needs allowance determined under subparagraph (B).

"(B) APPLICABLE PERSONAL NEEDS ALLOWANCE.—

"(i) INSTITUTIONALIZED INDIVIDUALS.—In the case of an institutionalized individual, the applicable personal needs allowance is an amount—

"(I) which is reasonable in amount for personal needs of the individual while in an institution, and

"(II) which is not less (and may be greater) than $50 per month.

"(ii) INDIVIDUALS RECEIVING HOME AND COMMUNITY BASED SERVICES.—In the case of an individual receiving home and community based services, the applicable personal needs allowance is an amount determined appropriate by the State, including amounts necessary to pay for food, shelter, and utilities.

"(iii) DEFINITION.—For purposes of this subparagraph, the term 'institutionalized individual' means an individual—

"(I) who is an inpatient in a nursing facility for which payments are made under this part throughout a month, and

"(II) who is determined to be eligible for long-term care assistance under the State plan.

"(3) POST-ELIGIBILITY MONTHLY INCOME.—For purposes of this subsection, the term 'post-eligibility monthly income' means—

"(A) in the case of an individual whose monthly income is equal to or less than 100 percent of the income official poverty line, an amount equal to such individual's monthly income; and

"(B) in the case of an individual whose monthly income exceeds 100 percent of the income official poverty line, an amount equal to 100 percent of the income official poverty line.

"PAYMENT TO STATES

"SEC. 2103. (a) IN GENERAL.—Except as otherwise provided in this section, the Secretary shall pay to each

State which has a plan approved under this part, for each quarter—

"(1) an amount equal to the Federal long-term care assistance percentage (as defined in section 2115(c)) of the total amount expended during such quarter as long-term care assistance under the State plan;

"(2)(A) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional personnel, and staff directly supporting such personnel, of the State agency or any other public agency;

"(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended during such quarter under this part for nursing aide training and competency evaluation programs described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent of so much of the sums

expended during such quarter under this part (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs;

"(C) an amount equal to 75 percent of so much of the sums expended during such quarter under this part (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); and

"(D) an amount equal to 75 percent of so much of the sums expended during such quarter under this part (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g);

"(3) an amount equal to—

"(A) 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical and effective administration of the

State plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this part,

"(B) 75 percent of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the State plan of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services, and

"(C) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of utilization review or quality review;

"(4) an amount equal to 100 percent of the sums expended during such quarter under this part which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d);

"(5) subject to subsection (b) an amount equal to—

"(A) 90 percent of the sums expended during such a quarter within the 12-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

"(B) 75 percent of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of long-term care assistance provided under the State plan) which are attributable to the establish-

ment and operation of (including the training of personnel employed by) a State long-term care fraud control unit (as defined in section 2115(m)); and

"(6) subject to section 1919(g)(3)(B), an amount equal to 50 percent of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) LIMIT ON THE AMOUNT OF PAYMENT.—The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(5) may not exceed one-quarter of 1 percent of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this part.

"(c) ESTIMATE OF QUARTERLY PAYMENT TO STATE.—

"(1) IN GENERAL.—Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter. Such estimates shall be based on—

"(A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions

of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and

"(B) such other investigation as the Secretary may find necessary.

"(2) PAYMENTS.—

"(A) IN GENERAL.—The Secretary shall pay to the State, in such installments as the Secretary may determine, the amount estimated under paragraph (1), reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

"(B) THIRD PARTY REIMBURSEMENTS.—Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State

or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 2102(a)(8).

"(C) OVERPAYMENT BY A STATE.—

"(i) IN GENERAL.—For purposes of this subsection, when an overpayment by a State to a person or other entity is discovered, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in clause (ii), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

"(ii) SPECIAL RULE.—In any case where the State is unable to recover an overpayment (or any portion of such overpayment) made to a person or other entity on account of such overpayment having been a debt discharged in bankruptcy or otherwise being uncollectible, no adjustment shall be made in the Federal pay-

ment to such State on account of such overpayment (or portion of such overpayment).

"(iii) AMOUNTS RECOVERED.—The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision of the State with respect to long-term care assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(3) APPROPRIATIONS DEEMED OBLIGATED.—Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"(4) OVERPAYMENTS TO STATES.—In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the

option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this part, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the dates such amount was disallowed and ending on the date of such final determination at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.

"(d) PROHIBITIONS ON PAYMENT.—Payment under the preceding provisions of this section shall not be made—

"(1) with respect to any amount expended for long-term care assistance—

"(A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under this part or title XI, or

"(B) for home and community based services to reimburse (or otherwise compensate) a provider of such services for payment of a civil money penalty imposed under this part or title XI; and

"(2) with respect to any amount expended to reimburse (or otherwise compensate) any provider of long-term care services under this part for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

"(e) ADJUSTMENT OF PAYMENTS.—Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 2109.

"(f) PROHIBITION ON PAYMENT IN CASES OF EXCLUSION CONTRACTS.—Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for long-term care assistance provided for an individual under the State's plan approved under this part to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance con-

tract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided long-term care assistance under the plan.

"(g) PAYMENT FOR COLLECTION OF SUPPORT OR PAYMENT UNDER COOPERATIVE ARRANGEMENT.—

"(1) IN GENERAL.—When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 2107, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for long-term care assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

"(2) ALLOCATION WHERE MULTIPLE JURISDICTIONS INVOLVED.—Where more than one jurisdiction is involved in an enforcement or collection under paragraph (1), the amount of the incentive payment determined under such paragraph shall be allocated

among the jurisdictions in a manner to be prescribed by the Secretary.

"(h) MECHANIZED CLAIMS PROCESSING AND RETRIEVAL SYSTEMS.—

"(1) IN GENERAL.—In order to receive payments under paragraph (3)(B) of subsection (a) without being subject to percent reductions set forth in paragraph (4)(B) of this subsection, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(A) and detailed in an advance planning document approved by the Secretary are operational on or before September 30, 1995.

"(2) APPROVAL OF SYSTEMS.—

"(A) IN GENERAL.—In order to receive payments under paragraph (3)(B) of subsection (a) without being subject to the percent reductions set forth in paragraph (4)(B) of this subsection, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A).

"(B) DEADLINE.—The deadline for approval of such systems for a State is the last

day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

"(C) DEEMED APPROVAL.—Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(A) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

"(3) FEDERAL MATCH.—When a State's systems are approved, the 75 percent Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1).

"(4) REVIEW OF SYSTEMS.—

"(A) IN GENERAL.—The Secretary shall review all approved systems not less often than once every 3 years, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under

paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a percent reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period. Reviews may, at the Secretary's discretion, constitute reviews of the entire system or only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.

"(B) DISAPPROVAL OF SYSTEM.—If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State, for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the percent specified in subsection (a)(3)(B) to a percent of not less than 50 percent and not more than 70 percent as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State, except that such percent may not be reduced by more than 10

percentage points in any 4-quarter period by reason of this subparagraph. No State shall be subject to a percent reduction under this paragraph before the fifth quarter beginning after such State's systems were initially approved.

"(C) WAIVER.—The Secretary may retroactively waive a percent reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this part, except that no such waiver may extend beyond the 4 quarters immediately prior to the quarter in which the State's systems are reapproved.

"(5) REQUIREMENTS FOR INITIAL APPROVAL.—

"(A) IN GENERAL.—In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of the type described in subsection (a)(3)(A) and must meet the following requirements:

"(i) The systems must be capable of developing provider and patient profiles

which are sufficient to provide specific information as to the use of covered types of services and items.

"(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's long-term care fraud control unit (if any).

"(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

"(B) REAPPROVAL.—In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of clauses (i) and (ii) of subparagraph (A) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

"(6) DEVELOPMENT OF PERFORMANCE STANDARDS.—The Secretary, with respect to State systems, shall—

"(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to ensure that all such performance standards and other requirements are met;

"(B) develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least 6 months during each fiscal year to ensure that all such performance standards and other requirements are met on a continuous basis;

"(C) provide that reviews for reapproval shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no percent re-

duction shall be made under paragraph (4) on the basis of such a review;

"(D) ensure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

"(E) notify all States of proposed procedures, standards, and other requirements at least 1 quarter prior to the fiscal year in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

"(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

"(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity

of such systems to effectively detect cases of fraud or abuse;

"(H) for the purpose of ensuring compatibility between the State systems and the systems utilized in the administration of title XVIII and title XIX—

"(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans approved under this part or under title XVIII or XIX, and beneficiaries of medical services under such plans or title;

"(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

"(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan approved under this part or under title XVIII or XIX;

"(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

"(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accordance with section 2102(a)(8)(A)(ii).

"(i) PAYMENT PROHIBITED FOR ERRONEOUS EXCESS PAYMENTS BEYOND A CERTAIN LEVEL.—

"(1) IN GENERAL.—

"(A) PAYMENT PROHIBITED.—Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for long-term care assistance (as defined in subparagraph (D)) to its total expenditures for long-term care assistance under the State plan approved under this part exceeds 0.03 for any full fiscal year, then the Secretary shall make no payment for such fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

"(B) WAIVER.—The Secretary may waive, in certain limited cases, all or part of the reduc-

tion required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

"(C) ESTIMATIONS.—In estimating the amount to be paid to a State under subsection (c), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate the Secretary makes under subsection (c)(1), for purposes of payment to the State under subsection (c)(2), in light of any expected erroneous excess payments for long-term care assistance (estimated in accordance with such criteria, including sampling procedures, as the Secretary may prescribe and subject to subsequent adjustment, if necessary, under subsection (c)(2)).

"(D) DEFINITION.—

"(i) IN GENERAL.—For purposes of this subsection, the term 'erroneous excess payments for long-term care assistance' means the total of—

"(I) payments under the State plan with respect to ineligible individuals and families, and

"(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for long-term care services required of an individual or a family as a condition of eligibility.

"(ii) INELIGIBLES.—In determining the amount of erroneous excess payments for long-term care assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowance resource level established under the State plan.

"(iii) ERRORS.—In determining the amount of erroneous excess payments for long-term care assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for long-term care services by the individual or family and the amount which should have been incurred in order to establish eligibility for long-term care assistance.

"(iv) THIRD-PARTY LIABILITY.—In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 2107(a)(1)(B) or 402(a)(26)(C).

"(E) EXCLUSIONS.—For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments

made for long-term care assistance and total expenditures for long-term care assistance—

"(i) payments with respect to any individual whose eligibility for long-term care assistance was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

"(ii) payments made as the result of a technical error.

"(2) PROVISION OF INFORMATION.—The State agency administering the plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data the Secretary requests that are reasonably necessary for the Secretary to carry out the provisions of this subsection.

"(3) STATE FAILURE TO COOPERATE.—

"(A) IN GENERAL.—If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as the Secretary may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to the Secretary and in accordance with such techniques for sampling and estimating as the Secretary finds appropriate.

"(B) REDUCTION FOR COSTS.—In any case in which it is necessary for the Secretary to exercise the Secretary's authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

"(4) APPLICABILITY.—This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

"(j) PAYMENT PROHIBITED FOR ASSISTANCE TO NONRESIDENT ALIENS.—Notwithstanding the preceding provisions of this section, no payment may be made to a State under this section for long-term care assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

"(k) DISALLOWANCE OF CLAIMS BY STATES.—

"(1) IN GENERAL.—In any case in which the Secretary proposes to disallow under section 1116(d) a claim by a State under this section, the Secretary shall, if the proposed disallowance is described in paragraph (2)(A), follow the procedure described in paragraph (2)(B). The Secretary may disallow such claim only if the State fails to take the action specified in paragraph (2)(B).

"(2) APPLICABLE DISALLOWANCES AND PROCEDURE.—

"(A) APPLICABLE DISALLOWANCES.—The procedure described in subparagraph (B) applies to any proposed disallowance where there is no contention by the Secretary that the services rendered were not medically necessary and appropriate, or that the quality of care provided

to eligible individuals was deficient and the proposed disallowance is not based upon—

"(i) an erroneous determination of eligibility of individuals;

"(ii) services of a type that are not covered by this part;

"(iii) services provided by an ineligible provider;

"(iv) erroneous computation of a State's indirect cost allocation rate or an ineligible provider's rate;

"(v) claims based on an inapplicable Federal long-term care assistance percentage; or

"(vi) failure to comply with utilization control procedures.

"(B) PROCEDURE.—In the case of any proposed disallowance described in subparagraph (A) the Secretary shall notify the State of the Secretary's intent to disallow a claim. Within 60 days of receipt of such notice, the State may inform the Secretary of its intention to alter its program or practices on a prospective basis to satisfy the matters on which the proposed disallowance is based, in which event

the Secretary shall review the State's program or practices, as appropriate, to assure that the necessary changes have been made or will be made within a reasonable time.

"(3) DETERMINATION OF AMOUNT OF DISALLOWANCE.—Whenever the Secretary disallows any claim by a State under this section, whether or not described in paragraph (2)(A) of this subsection, and the State exercises its right of reconsideration under section 1116(d), the Department Appeals Board established in the Department of Health and Human Services shall, if such Board upholds the basis for the disallowance, determine whether the amount of the disallowance should be reduced. In making this determination, the Board shall take into account (to the extent the State makes a showing) factors which shall include, but not be limited to—

"(A) whether the basis of the disallowance was procedural in nature;

"(B) whether the amount of the disallowance is proportionate to the error or deficiency on which the disallowance is based;

"(C) whether the basis of the disallowance constitutes noncompliance that prevented or

materially affected the provision of appropriate services of recipients eligible under this part; or

"(D) whether Federal guidance with respect to the action that is the basis for the proposed disallowance was insufficient and the State made good faith efforts to conform its action to the intent of the applicable Federal statute or regulation.

"(4) NO DISALLOWANCE IF ACTION CONSISTENT WITH STATE PLAN.—No disallowance shall be taken or upheld if action of the State on which the disallowance would be based is consistent with its approved State plan.

"(5) INTEREST.—In any case of a disallowance as to which the State does not elect to retain the amount of the Federal payment in dispute pending a final determination with respect to such payment amount, and such final determination (either by administrative or judicial decision) is to the effect that such payment amount, or any portion thereof, shall not be disallowed, the State shall be entitled to interest on the amount determined not to be disallowed for the period beginning on the date such amount was disallowed and ending on the date of

such final determination at the rate specified in subsection (c)(4).

"(6) AUDIT OR FINANCIAL REVIEW.—No disallowance of a claim under this section may be taken with respect to any amounts paid to a State unless an audit or financial review with respect to such amounts has been initiated, and the State has been informed that the audit has been initiated, within 3 years of the date of filing of the State's claim for such amounts.

"(l) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the provisions of subsection (w) of section 1903 shall apply to payments to States under this section in the same manner as they apply to payments to States under subsection (a) of such section.

"(2) ADDITIONAL HEALTH CARE ITEMS AND SERVICES.—For purposes of paragraph (1), subsection (w)(7)(A) of section 1903 shall be applied by adding case management services and home and community based services to the health care items and services listed in such subsection.

"OPERATION OF STATE PLANS

"SEC. 2104. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this part, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 2102; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision,

the Secretary shall notify such State agency that further payments will not be made to the State (or, in the Secretary's discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied, the Secretary shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"OBSERVANCE OF RELIGIOUS BELIEFS

"SEC. 2105. Nothing in this part shall be construed to require any State which has a plan approved under this part to compel any person to receive services under the plan (other than for the purpose of discovering and pre-

venting the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person objects to the receipt of such services on religious grounds.

"INDIAN HEALTH SERVICE PROVIDERS

"SEC. 2106. (a) ELIGIBILITY FOR PAYMENT.—An Indian Health Service provider (including a nursing facility, or any other provider of services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for long-term care assistance provided under a State plan if and for so long as the provider meets all of the conditions and requirements which are applicable generally to such providers under this part.

"(b) SUBMISSION OF PLAN FOR ELIGIBILITY.—Notwithstanding subsection (a), an Indian Health Service provider (including a nursing facility, or any other provider of services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this part which are applicable generally to such provider, but which submits to the Secretary within 6 months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such

conditions and requirements (and to be eligible for reimbursement under this part), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

"ASSIGNMENT OF RIGHTS OF PAYMENT

"SEC. 2107. (a) IN GENERAL.—For the purpose of assisting in the collection of long-term care support payments and other payments for long-term care owed to recipients of long-term care assistance under the State plan approved under this part, a State plan for long-term care assistance shall—

"(1) provide that, as a condition of eligibility for long-term care assistance under the State plan to an individual who has the legal capacity to execute an assignment on the individual's own behalf, the individual is required—

"(A) to assign the State any rights, of the individual or of any other person who is eligible for long-term care assistance under this part and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of long-term care by a court or administrative order) and to payment for long-term care from any third party; and

"(B) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

"(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for long-term care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to the enforcement and collection of rights to support or payment assigned under this section, and any other matters of common concern.

"(b) DISTRIBUTION OF AMOUNTS COLLECTED.—Such part of any amount collected by the State under an assignment made under the provisions of this section shall

be retained by the State as is necessary to reimburse the State for long-term care assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such long-term care assistance), and the remainder of such amount collected shall be paid to such individual.

"HOSPITAL PROVIDERS OF NURSING FACILITY SERVICES

"SEC. 2108. (a) IN GENERAL.—Notwithstanding any other provision of this part, payment may be made, in accordance with this section, under a State plan approved under this part for nursing facility services furnished by a hospital which has in effect an agreement under section 1883 and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1919.

"(b) PAYMENT FOR SERVICES.—

"(1) IN GENERAL.—Except as provided in paragraph (3), payment to any such hospital for any nursing facility services furnished pursuant to subsection (a) shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing facilities located in the State in which the hospital is located. The reasonable cost of ancillary

services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) ALLOCATION OF COSTS.—With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

"(3) PAYMENT RATES.—Payment to any hospital for any nursing facility services furnished pursuant to subsection (a) may be made at a payment rate established by the State in accordance with the requirements of section 2102(a)(7)(C)(i).

"WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE AND MEDICAID PROVIDERS

"SEC. 2109. (a) IN GENERAL.—

"(1) MEDICARE PROGRAM.—The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expend-

itures for long-term care assistance for services furnished in any quarter by—

"(A) an institution—

"(i) which has or previously had in effect an agreement with the Secretary under section 1866; and

"(ii)(I) from which the Secretary has been unable to recover overpayments made under title XVIII, or (II) from which the Secretary has been unable to collect the information necessary to enable the Secretary to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

"(B) any person—

"(i) who (I) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (II) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII which aggregated less than the amount of overpayments made to such person, and

"(ii)(I) from whom the Secretary has been unable to recover overpayments re-

ceived in violation of the terms of such assignment, or (II) from whom the Secretary has been unable to collect the information necessary to enable such person to determine the amount (if any) of the overpayments made to such person under title XVIII.

"(2) MEDICAID PROGRAM.—The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for long-term care assistance for services furnished in any quarter by—

"(A) an institution (i) from which the Secretary has been unable to recover overpayments made under title XIX, or (ii) from which the Secretary has been unable to collect the information necessary to enable the Secretary to determine the amount (if any) of the overpayments made to such institution under title XIX; and

"(B) any person (i) from whom the Secretary has been unable to recover overpayments made under title XIX, or (ii) from whom the Secretary has been unable to collect the information necessary to enable such person to de-

termine the amount (if any) of the overpayments made to such person under title XIX.

"(b) REDUCTION OF PAYMENT TO STATES.—The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this part for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII or XIX, and may require the State to reduce its payment to such institution or person by such amount.

"(c) NOTICE OF REDUCTION.—The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person pursuant to subsection (b), until after the Secretary has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

"(d) REGULATORY PROCEDURES.—The Secretary shall by regulation provide procedures for implementation of this section. Such procedures shall—

"(1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be

treated as a setoff against overpayments under title XVIII or XIX; and

"(2) assure the restoration to the institution or person of amounts withheld under this section that are ultimately determined to be in excess of overpayments under title XVIII or XIX and to which the institution or person would otherwise be entitled under this part.

"(e) AMOUNTS RECOVERED RESTORED TO TRUST FUNDS.—The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

"(f) CERTAIN AMOUNTS NOT RECOVERABLE.—Notwithstanding any other provision of this part, an institution or person shall not be entitled to recover from any State any amount in payment for long-term care services under this part that is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

"PROVISIONS RESPECTING INAPPLICABILITY OF CERTAIN REQUIREMENTS

"SEC. 2110. (a) IN GENERAL.—A State shall not be deemed to be out of compliance with the requirements of paragraph (1)(B), (2), or (6) of section 2102(a) solely by reason of the fact that the State (or any political subdivision of the State)—

"(1) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for long-term care assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization; or

"(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for long-term care assistance for items or services under the State plan) can receive such items or services, if—

"(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not necessary (as determined in accordance with utilization guidelines established by the State), and

"(B) under such restriction, individuals eligible for long-term care assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

"(b) CASE MANAGEMENT SERVICES EXEMPTED FROM CERTAIN REQUIREMENTS.—A State may provide, as long-term care assistance, case management services under the plan without regard to the requirements of paragraphs (1)(B) and (2)(B) of section 2102(a). The provision of case management services under this subsection shall not restrict the choice of the individual to receive long-term care assistance in violation of section 2102(a)(6). The State may limit the case managers available with respect to case management services for eligible individuals in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

"USE OF DEDUCTIBLE, COST SHARING, AND SIMILAR CHARGES

"SEC. 2111. (a) IN GENERAL.—The State plan shall provide that any deductible, cost sharing, or similar charge imposed under the plan will be nominal in amount (as determined by the Secretary in regulations).

"(b) NONDENIAL OF CARE.—The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care

or services were furnished for payment of the deductible, cost sharing, or similar charge.

"TRANSFERS OF ASSETS, TRUSTS, LIENS, AND ADJUSTMENTS AND RECOVERIES

"SEC. 2112. (a) PROHIBITION ON ELIGIBILITY UNDER CERTAIN CIRCUMSTANCES.—

"(1) REQUIRED PERIODS OF INELIGIBILITY.—

"(A) IN GENERAL.—In order to meet the requirements of this section (for purposes of section 2102(a)(3)(D), the State plan must provide for a period of ineligibility for long-term care assistance during the period beginning on the date specified in subparagraph (C) and equal to the number of months specified in subparagraph (D) in the case of an individual who, or whose spouse, at any time on or after the look-back date specified in subparagraph (B)(i)—

"(i) disposed of assets for less than fair market value;

"(ii) transferred assets (or ownership or control of such assets) to a trustee, fiduciary, or other person or entity; or

"(iii) converted countable resources to noncountable resources.

"(B) LOOK-BACK DATE.—

"(i) IN GENERAL.—The look-back date specified in this subparagraph is a date that is—

"(I) 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (b), 60 months) before the date specified in clause (ii); or

"(II) at the option of the State, such earlier date as provided by the State where there is reasonable cause to believe that an individual engaged in the activities described in clause (i), (ii), or (iii) of subparagraph (A) solely for the purposes of qualifying for long-term care assistance under this part.

"(ii) DATE SPECIFIED.—The date specified in this clause, with respect to—

"(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for long-

term care assistance under the State plan, or

"(II) a noninstitutionalized individual is the date on which the individual applies for long-term care assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

"(C) BEGINNING DATE OF PERIOD OF INELIGIBILITY.—The date specified in this subparagraph is the first day of the first month in which the individual—

"(i) is an institutionalized individual;

"(ii) is (or but for the provisions of this subsection would be) entitled to long-term care assistance under the State plan; and

"(iii) is receiving or is an applicant for such long-term care assistance.

"(D) PERIOD OF INELIGIBILITY.—

"(i) INSTITUTIONALIZED INDIVIDUALS.—With respect to an institutionalized individual, the number of months of ineli-

gibility under this subparagraph for an individual shall be equal to—

"(I) the total, cumulative uncompensated value of all assets or resources transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

"(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

"(ii) NONINSTITUTIONALIZED INDIVIDUALS.—With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

"(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back

date specified in subparagraph (B)(i), divided by

"(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

"(iii) REDUCTION IN PERIOD OF INELIGIBILITY.—The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

"(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

"(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

"(2) EXCEPTION TO INELIGIBILITY.—An individual shall not be ineligible for long-term care assistance by reason of paragraph (1) to the extent that—

"(A) ownership of the assets was transferred to—

"(i) the spouse of such individual; or

"(ii) a child of such individual who—

"(I) is under age 21,

"(II) with respect to States eligible to participate in the State program established under title XVI, is blind or permanently and totally disabled, or

"(III) with respect to States which are not eligible to participate in such program, is blind or disabled as defined in section 1614 who is determined by the State to be financially dependent on such individual;

"(B) the assets—

"(i) were transferred to, or to a trust (including a trust described in subsection (b)(4)) established solely for the benefit of,

the individual's child described in subparagraph (A)(ii)(II), or

"(ii) were transferred to a trust (including a trust described in subsection (b)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1614(a)(3));

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that—

"(i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration;

"(ii) the assets were transferred or converted in accordance with a court order; or

"(iii) assets transferred for less than fair market value have been returned to the individual; or

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) JOINT OWNERSHIP.—For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar ar-

rangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

"(4) PERIODS OF INELIGIBILITY IN ACCORDANCE WITH THIS SUBSECTION; APPORTIONING PERIODS OF INELIGIBILITY.—A State may not provide for any period of ineligibility for an individual due to transfer of assets for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for long-term care assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for long-term care assistance under the State plan.

"(b) TRUSTS.—

"(1) IN GENERAL.—For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this part, subject to

paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

"(2) ESTABLISHMENT OF TRUSTS.—

"(A) IN GENERAL.—For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

"(i) The individual.

"(ii) The individual's spouse.

"(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

"(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"(B) JOINT OWNERSHIP.—In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to

the portion of the trust attributable to the assets of the individual.

"(C) APPLICABILITY.—Subject to paragraph (4), this subsection shall apply without regard to—

"(i) the purposes for which a trust is established,

"(ii) whether the trustees have or exercise any discretion under the trust,

"(iii) any restrictions on when or whether distributions may be made from the trust, or

"(iv) any restrictions on the use of distributions from the trust.

"(3) RULES APPLICABLE TO TRUSTS.—

"(A) REVOCABLE TRUSTS.—In the case of a revocable trust—

"(i) the corpus of the trust shall be considered resources available to the individual,

"(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

"(iii) any other payments from the trust shall be considered assets disposed of

by the individual for purposes of subsection (a).

"(B) IRREVOCABLE TRUSTS.—In the case of an irrevocable trust—

"(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

"(I) to or for the benefit of the individual, shall be considered income of the individual, and

"(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (a); and

"(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establish-

ment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (a), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

"(4) EXCEPTIONS.—This subsection shall not apply to any of the following trusts:

"(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3)) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total long-term care assistance paid on behalf of the individual under a State plan under this part.

"(B) A trust established in a State for the benefit of an individual if—

"(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust), and

"(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total long-term care assistance paid on behalf of the individual under a State plan under this part.

"(C) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) that meets the following conditions:

"(i) The trust is established and managed by a non-profit association.

"(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

"(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

"(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of long-term care assistance paid on behalf of the beneficiary under the State plan under this part.

"(5) HARDSHIP PROVISION.—The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

"(6) TRUST.—For purposes of this subsection, the term 'trust' includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

"(c) IMPOSITION OF LIEN.—

"(1) IN GENERAL.—In order to meet the requirements of this section (for purposes of section

2102(a)(3)(D)) a lien may be imposed against the real property of any individual as a condition of receiving payment for long-term care assistance under the State plan.

"(2) DISSOLUTION OF LIEN.—Any lien imposed with respect to an individual pursuant to paragraph (1) shall dissolve (without regard to otherwise applicable State law) upon that individual's—

"(A)(i) not owing any amounts paid as long-term care assistance under the State plan; and

"(ii) no longer receiving long-term care assistance under such plan; or

"(B) discharge from a nursing facility where the individual makes a reasonable showing that such lien imposes an undue hardship.

"(d) RECOVERY OF LIEN.—

"(1) IN GENERAL.—In order to meet the requirements of this section (for purposes of section 2102(a)(3)(D)), the State shall seek adjustment or recovery of any long-term care assistance correctly paid on behalf of an individual under the State plan (including foreclosure on a lien imposed under subsection (c)).

"(2) CONDITIONS WHERE ADJUSTMENT OR RECOVERY PERMITTED.—Any adjustment or recovery under paragraph (1) may be made only—

"(A) after the death of the individual and such individual's surviving spouse, if any; and

"(B) at a time when the individual has no surviving child who—

"(i) is under age 21;

"(ii) with respect to States eligible to participate in the State program established under title XVI, is blind or permanently and totally disabled; or

"(iii) with respect to States which are not eligible to participate in such program, is blind or disabled as defined in section 1614.

"(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

"(e) DEFINITIONS.—For purposes of this section:

"(1) ASSETS.—The term 'assets', with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

"(A) by the individual or such individual's spouse,

"(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

"(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

"(2) INCOME.—The term 'income' has the meaning given such term in section 1612.

"(3) INSTITUTIONALIZED INDIVIDUAL.—The term 'institutionalized individual' means an individual who is an inpatient in a nursing facility.

"(4) NONINSTITUTIONALIZED INDIVIDUAL.—The term 'noninstitutionalized individual' means an individual receiving home and community based services.

"(5) RESOURCES.—The term 'resources' has the meaning given such term in section 1613 without regard to the exclusions described in paragraphs (1) and (2)(A) of subsection (a) of such section.

"APPLICATION OF PROVISIONS OF TITLE II RELATING TO SUBPOENAS

"SEC. 2113. The provisions of subsections (d) and (e) of section 205 shall apply with respect to this part to the same extent as they are applicable with respect to title II.

"TREATMENT OF INCOME AND RESOURCES FOR IMPAIRED SPOUSES

"SEC. 2114. (a) SPECIAL TREATMENT FOR IMPAIRED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for long-term care assistance of an impaired spouse (as defined in subsection (f)(1)), the provisions of this section supersede any other provision of this part which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for impaired spouses shall not require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing long-term care assistance to its residents under waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this part.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is 1 of the 50 States or the District of Columbia.

"(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS.—This section applies to individuals receiving institutional or noninstitutional services from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an impaired spouse is in the institution, except as provided in paragraph (2) no income of the community spouse shall be deemed available to the impaired spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an impaired spouse or community spouse, for purposes of the posteligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NONTRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument

providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the impaired spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the impaired spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the impaired spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this part, and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the impaired spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the impaired spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the impaired spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such

interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the impaired spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an impaired spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first period of eligibility of the impaired spouse)—

"(i) the total value of resources to the extent either the impaired spouse or the

community spouse has an ownership interest, and

"(ii) a spousal share which is equal to one-half of such total value.

"(B) ASSESSMENT.—At the request of an impaired spouse or community spouse, as of the beginning of the first period of eligibility of the impaired spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for long-term care assistance under this part, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (d)(2).

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an impaired spouse at the time of application for benefits under this part, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the impaired spouse, community spouse, or both, shall be considered to be available to the impaired spouse, and

"(B) resources shall be considered to be available to an impaired spouse.

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The impaired spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the impaired spouse has assigned to the State any rights to support from the community spouse;

"(B) the impaired spouse lacks the ability to execute an assignment due to physical or mental impairment, but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an impaired spouse is in an institution and after the month in which an impaired spouse is determined to be eligible for benefits under this part, no resources of the community spouse shall be deemed available to the impaired spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' has the meaning given such term in section 1613 without regard to the exclusions described in paragraphs (1) and (2)(A) of subsection (a) of such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF IMPAIRED SPOUSE.—After an impaired spouse is determined or redetermined to be eligible for long-term care assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's

monthly income the following amounts in the following order:

"(A) A personal needs allowance in an amount not less than the amount specified in section 2102(g)(2)(B).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the impaired spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (d), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds 150 percent of one-twelfth of the income official poverty line (as defined in section 2115(f)) for a family unit of 2 members plus an excess shelter allowance (as defined in paragraph (4)). A revision of the official poverty line shall apply to long-term care services furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance estab-

lished under subparagraph (A) may not exceed $1,500 (subject to adjustment under subparagraph (C) and subsection (e)).

"(C) INDEXING DOLLAR AMOUNT.—The dollar amount specified in subparagraph (B) during a fiscal year after fiscal year 1995 shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1994 and the September before the fiscal year involved.

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance used by the State under section 9(e) of the Food Stamp Act of 1977 or, if the State does not use such

an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) COURT ORDERED SUPPORT.—If a court has entered an order against an impaired spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) NOTICE AND FAIR HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for long-term care assistance of an impaired spouse, or

"(B) a request by either the impaired spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph

(B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B), of the amount of any family allowances (described in subsection (d)(1)(C)), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the impaired spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1); or

"(iv) the attribution of resources under subsection (c)(2);

such spouse is entitled to a fair hearing described in section 2102(a)(1)(F) with respect to

such determination if an application for benefits under this part has been made on behalf of the impaired spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(f) DEFINITIONS.—For purposes of this section:

"(1) IMPAIRED SPOUSE.—The term 'impaired spouse' means an individual who—

"(A) is receiving services under this part, and

"(B) is married to a spouse who is not a functionally impaired or severely functionally impaired individual;

but does not include any such individual who does not meet the requirements of subparagraph (A) for at least 30 days.

"(2) COMMUNITY SPOUSE.—The term 'community spouse' means the spouse of a functionally impaired or severely functionally impaired individual.

"DEFINITIONS

"SEC. 2115. (a) CASE MANAGEMENT SERVICES.—For purposes of this part, the term 'case management services' means services which—

"(1) maximize the independent functioning of individuals eligible for long-term care assistance under the State plan in the least restrictive environment possible;

"(2) coordinate the most appropriate mixture of long-term care services for such individuals; and

"(3) contain costs through the appropriate organization of the available resources and sequencing of services to respond to the functional and long-term care needs of such individuals.

"(b) COMPREHENSIVE FUNCTIONAL ASSESSMENT DEFINED.—For purposes of this part, the term 'comprehensive functional assessment' means an assessment which—

"(1) is conducted by a qualified community care case manager;

"(2) is used to determine whether or not an individual is a functionally impaired individual, a severely functionally impaired individual, or a functionally impaired child;

"(3) uses an instrument which has been specified by the State;

"(4) is used in establishing, reviewing, and revising an individual's individual community care plan;

"(5) is provided free of charge to the individual receiving the assessment;

"(6) includes an interview with the individual and such individual's primary caregiver, where appropriate, to determine the individual's—

"(A) ability or inability to perform the activities of daily living described in subsection (c)(4);

"(B) health status;

"(C) mental status;

"(D) current living arrangements; and

"(E) formal and informal long-term care support systems;

"(7) includes a schedule for reassessment of the individual within a reasonable period after the initial assessment if the physical or cognitive status of the

individual is determined to be likely to change significantly;

"(8) for each individual who is determined to be a functionally impaired individual, severely functionally impaired individual, or a functionally impaired child, includes a periodic review of such individual's status and assessment and a revision of such individual's individual community care plan by the qualified community care case manager as appropriate, but no less often than once every 6 months;

"(9) includes the development of an individual community care plan; and

"(10) includes arrangement by the qualified community care case manager, in consultation with the individual's primary medical care provider, for the provision of appropriate care and services.

"(c) FEDERAL LONG-TERM CARE ASSISTANCE PERCENTAGE DEFINED.—

"(1) IN GENERAL.—The term 'Federal long-term care assistance percentage' for any State shall be 100 percent less the State percentage, and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the

square of the per capita income of the continental United States (including Alaska and Hawaii).

"(2) SPECIAL RULES.—Notwithstanding paragraph (1)—

"(A) the Federal long-term care assistance percentage shall in no case be less than 50 percent or more than 80 percent,

"(B) the Federal long-term care assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 percent, and

"(C) the Federal long-term care assistance percentage shall be 100 percent with respect to amounts expended as long-term care assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

"(3) DETERMINATION.—The Federal long-term care assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

"(d) FUNCTIONALLY IMPAIRED DEFINED.—

"(1) FUNCTIONALLY IMPAIRED INDIVIDUAL.—For purposes of this part, the term 'functionally impaired individual' means an individual 6 years of age or older who is certified by a licensed health care practitioner (other than a relative of such individual) as being unable to perform at least 3 of the activities of daily living described in subparagraph (A) of paragraph (4) on a daily basis for a period of at least 60 consecutive days, without substantial assistance from another individual (including assistance involving verbal reminding, physical cueing, or substantial supervision).

"(2) SEVERELY FUNCTIONALLY IMPAIRED INDIVIDUAL.—For purposes of this part, the term 'severely functionally impaired individual' means an individual 6 years of age or older who is certified by a licensed health care practitioner (other than a relative of such individual) as being unable to perform more than 3 of the activities of daily living described in subparagraph (A) of paragraph (4) on a daily basis for a period of at least 60 consecutive days, without substantial assistance from another individual (including assistance involving verbal reminding, physical cueing, or substantial supervision).

"(3) FUNCTIONALLY IMPAIRED CHILD.—

"(A) IN GENERAL.—For purposes of this part, the term 'functionally impaired child' means an individual under 6 years of age who is certified by a licensed health care practitioner (other than a relative of such individual) as having comparable levels of functional impairment which would entitle such individual to benefits under this part.

"(B) COMPARABLE LEVELS OF FUNCTIONAL IMPAIRMENT.—In subparagraph (A), the term 'comparable levels of functional impairment' means physical, cognitive, or other impairments that limit the ability of an individual who is under 6 years of age to perform activities of daily living appropriate for the age of the individual on a daily basis for a period of at least 60 consecutive days and that are comparable to the physical, cognitive or other impairments of a functionally impaired individual or a severely functionally impaired individual.

"(4) ACTIVITIES OF DAILY LIVING.—

"(A) DESCRIPTION.—The activities of daily living described in this paragraph are—

"(i) eating;

"(ii) transferring;

"(iii) toileting;

"(iv) dressing; and

"(v) bathing.

"(B) REQUIREMENTS ON THE SECRETARY.—The Secretary shall develop definitions and standards for measuring the ability to perform the activities of daily living described in subparagraph (A) in conjunction with—

"(i) experts in gerontology, pediatrics, and functional impairment research;

"(ii) representatives from appropriate State agencies that are involved in the provision of long-term care services;

"(iii) representatives of providers of long-term care services;

"(iv) representatives of insurance companies offering long-term care insurance;

"(v) representatives of consumers; and

"(vi) other individuals determined appropriate by the Secretary.

"(5) LICENSED HEALTH CARE PRACTITIONER.—For purposes of this part, the term 'licensed health care practitioner' means—

"(A) a physician or registered professional nurse, or

"(B) a qualified community care case manager.

"(e) HOME AND COMMUNITY BASED SERVICES DEFINED.—For purposes of this part, the term 'home and community based services' means services furnished in a home or other location (but not including such services furnished to an inpatient or resident of a nursing facility) required to meet the individual's activities of daily living-related needs including the following:

"(1) Homemaker services.

"(2) Personal care services.

"(3) Home health care.

"(4) Adult day health care.

"(5) Nursing services provided by or under the supervision of a registered nurse.

"(6) Physical therapy and related services.

"(7) Respite care.

"(f) INCOME OFFICIAL POVERTY LINE.—For purposes of this part, the term 'income official poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981).

"(g) INDIVIDUAL COMMUNITY CARE PLAN DEFINED.—For purposes of this part, the term 'individual community care plan' means a written plan which—

"(1) is in accordance with the long-term care service needs of the individual and the availability of the appropriate care and services;

"(2) identifies—

"(A) the long-term care problems and needs of the individual;

"(B) the mix of formal and informal services and support systems that are available to meet the long-term care service needs of the individual;

"(C) the goals for the individual;

"(D) the appropriate services necessary to meet such needs; and

"(E) the arrangements made for appropriate care and services;

"(3) is established, and is periodically reviewed and revised, by a qualified community care case manager in consultation with the individual's primary medical care provider, after a face-to-face interview with the individual and such individual's spouse or primary caregiver, where appropriate, and

based upon the most recent comprehensive functional assessment of such individual;

"(4) specifies, within any amount, duration, and scope, limitations imposed on care and services provided under the State plan, and indicates the individual's preferences for the types and providers of services;

"(5) may specify other services required by such individual; and

"(6) does not restrict or otherwise limit the specific persons or individuals (who are competent and authorized by the State to provide home and community based services under the State plan) who will provide the home and community based services described, except as otherwise described in this part.

"(h) LONG-TERM CARE ASSISTANCE DEFINED.—

"(1) IN GENERAL.—For purposes of this part, the term 'long-term care assistance' means payment of part or all of the cost of the following care and services for individuals described in section 2102(a)(2)(A):

"(A) Case management services provided by a qualified community care case manager.

"(B) Nursing facility services (other than services in an institution for mental diseases).

"(C) Home and community based services.

"(D) Any other type of long-term care service (other than room and board) recognized under State law as specified by the Secretary.

"(2) SPECIAL RULE.—The term 'long-term care assistance' does not include any payment of part or all of the cost of the care and services described in paragraph (1) for an individual described in section 2102(a)(2)(A) who is an inmate of a public institution.

"(i) NURSING FACILITY DEFINED.—For purposes of this part, the term 'nursing facility' has the meaning given such term under section 1919 and which meets the requirements for such a facility described in such section.

"(j) NURSING FACILITY SERVICES DEFINED.—For purposes of this part, the term 'nursing facility services' means services which are or were required to be given an individual who needs or needed, on a daily basis, nursing care (provided directly by or requiring the supervision of nursing personnel) which as a practical matter can only be provided in a nursing facility on an inpatient basis.

"(k) QUALIFIED COMMUNITY CARE CASE MANAGER.—For purposes of this part, the term 'qualified community care case manager' means a person or entity which—

"(1) provides case management services to an individual who is eligible for long-term care assistance under the State plan;

"(2) is not a relative of the individual receiving such case management services;

"(3) has experience in assessing individuals' functional and cognitive impairment;

"(4) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to individuals who are eligible for long-term care assistance under this part;

"(5) completes the individual community care plan in a timely manner and reviews and discusses new and revised individual community care plans with the individual or such individual's primary caregiver or both; and

"(6) meets such other standards established by the Secretary or the State which may include standards which assure—

"(A) the quality of case management services; and

"(B) that individuals whose home and community based services they manage are not

at risk of financial exploitation due to such a manager.

"(l) RELATIVE DEFINED.—For purposes of this part, the term 'relative' means an individual bearing a relationship to another individual which is described in paragraphs (1) through (8) of section 152(a) of the Internal Revenue Code of 1986.

"(m) STATE LONG-TERM CARE FRAUD CONTROL UNIT DEFINED.—For purposes of this part, the term 'State long-term care fraud control unit' means an identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the requirements described in section 1903(q), and such entity may be the same entity as the medicaid fraud unit described in such section.

"PART B—SECURE CHOICE INSURANCE PROGRAM

"PURPOSE

"SEC. 2131. This part establishes a public-private partnership to provide long-term care assistance to individuals through the expanded availability of long-term care insurance policies which cover care and services that are subsidized by Federal and State funding.

"DEFINITIONS

"SEC. 2132. For purposes of this part:

"(1) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' refers to the activities described in section 2115(d)(4).

"(2) BENEFIT SUBSIDY.—The term 'benefit subsidy' means the amount determined under section 2138(b)(2).

"(3) CASE MANAGEMENT SERVICES.—The term 'case management services' has the meaning provided in section 2115(a).

"(4) ELIMINATION PERIOD.—The term 'elimination period' means the period of time beginning on the date on which a policyholder qualifies for benefits under a qualified long-term care insurance policy issued under this part during which no benefits under such policy will be paid.

"(5) FUNCTIONALLY IMPAIRED INDIVIDUAL.—The term 'functionally impaired individual' has the meaning provided in section 2115(d)(1).

"(6) SEVERELY FUNCTIONALLY IMPAIRED INDIVIDUAL.—The term 'severely functionally impaired individual' has the meaning provided in section 2115(d)(2).

"(7) HOME AND COMMUNITY BASED SERVICES.—The term 'home and community based services' has the meaning provided in section 2115(e).

"(8) INCOME OFFICIAL POVERTY LINE.—The term 'income official poverty line' has the meaning provided in section 2115(f).

"(9) NURSING FACILITY SERVICES.—The term 'nursing facility services' has the meaning provided in section 2115(j).

"(10) POLICYHOLDER.—The term 'policyholder' means an individual who purchases a qualified long-term care insurance policy.

"(11) QUALIFIED CASE MANAGER.—The term 'qualified case manager' means a qualified community care case manager as defined in section 2115(k).

"(12) QUALIFIED INSURER.—The term 'qualified insurer' means an entity that is certified by the Standard and Performance Organization of a State (established under section 2141) as an entity that—

"(A) is licensed or certified under applicable State law to sell insurance in the State;

"(B) complies with State laws and meets or exceeds insurance standards of the National Association of Insurance Commissioners, adopted as of January of 1993;

"(C) uses case management services to monitor the needs of policyholders;

"(D) guarantees a loss ratio of not less than 60 percent for individual and group long-term care policies;

"(E) provides the Standards and Performance Organization with the underwriting criteria used by the insurer and such other information as may be required by such Organization; and

"(F) meets any other requirements established by the State insurance commission.

"(13) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—The term 'qualified long-term care insurance policy' means an insurance policy that meets the requirements of section 2134.

"(14) QUALIFIED PROVIDER.—The term 'qualified provider' means an individual or entity—

"(A) that provides long-term care services for which reimbursement is available under a qualified long-term care insurance policy; and

"(B) is in compliance with licensure and certification standards established by the State under part A.

"ESTABLISHMENT OF PROGRAM

"SEC. 2133. There is established a program (to be known as the 'Secure Choice Insurance Program') under which—

"(1) each State shall—

"(A) ensure that qualified insurers, qualified long-term care insurance policies, and qualified providers within the State meet the requirements under this part;

"(B) ensure that individuals have access to qualified long-term care insurance policies;

"(C) ensure that care and services provided under any long-term care insurance policy comply with the requirements of this part;

"(D) pay the benefit subsidy for the costs of care and services provided under qualified long-term care insurance policies as provided in section 2138(b)(2);

"(E) establish a Standards and Performance Organization in accordance with section 2141;

"(F) prepare and submit to the Secretary such reports as the Secretary may require, in such form, containing such information, and complying with such requirements as the Secretary determines necessary to assure the soundness, correctness, nonduplicative nature, and verification of such reports; and

"(G) otherwise comply with the requirements of this part; and

"(2) the Federal government shall contribute funds to reimburse the State for a portion of the expenditures by the State, in accordance with section 2139.

"REQUIREMENTS ON QUALIFIED LONG-TERM CARE INSURANCE POLICIES

"SEC. 2134. (a) IN GENERAL.—An insurance policy shall be treated as a qualified long-term care insurance policy meeting the requirements of this section if the policy—

"(1) is approved for sale in the State by the State insurance commission;

"(2) offers benefits that meet the requirements of section 2135;

"(3) offers premiums that meet the requirements of section 2136;

"(4) meets the portability requirements of section 2137;

"(5) provides payment for care and services furnished under such policy in accordance with section 2138(a);

"(6) provides for no more than a 30 cumulative day elimination period; and

"(7) meets the standards for long-term care insurance policies under subsection (h) of section 7702B of the Internal Revenue Code of 1986 and subsections (c), (d), and (e) of section 4980C of such Code.

"BENEFITS UNDER QUALIFIED LONG-TERM CARE INSURANCE POLICIES

"SEC. 2135. (a) SERVICES.—

"(1) MINIMUM BENEFITS.—

"(A) IN GENERAL.—Qualified long-term care insurance policies shall cover at least—

"(i) with respect to policyholders who are functionally impaired individuals, home and community based services and case management services; and

"(ii) with respect to policyholders who are severely functionally impaired individuals, nursing facility services, home and community based services, and case management services.

"(B) LIMITATIONS.—Qualified long-term care insurance policies shall pay only for services described in subparagraph (A)—

"(i) that are appropriate to assist a policyholder in performing activities of daily living, as determined by a qualified

case manager and specified under a written plan of care; and

"(ii) that are provided by qualified providers.

"(2) ADDITIONAL BENEFITS.—Qualified insurers may offer qualified long-term care insurance policies that provide for benefits in addition to those required under paragraph (1) if such policies are approved by the State insurance commission as meeting the requirements of this section.

"(3) REQUIREMENTS ON CASE MANAGEMENT SERVICES.—Any case management services furnished under a qualified long-term care insurance policy shall be provided in accordance with paragraph (4) and the standards established by the Standards and Performance Organization for the State.

"(4) PROVISION OF CASE MANAGEMENT SERVICES.—

"(A) ASSIGNMENT.—Upon a preliminary determination that a policyholder may be in need of care and services under a qualified long-term care insurance policy, the qualified insurer shall ensure that a qualified case man-

ager is assigned to provide case management services for such policyholder.

"(B) ACTIVITIES.—

"(i) BENEFITS ASSESSMENT.—An assessment shall be made by a qualified case manager to determine whether the policyholder is in need of care and services under the qualified long-term care insurance policy. In making such assessment, the qualified case manager shall conduct an interview with the policyholder to determine the functional level (in terms of performance of activities of daily living) and cognitive impairment status of the policyholder. Such benefits assessment shall include an assessment of the policyholder's—

"(I) ability or inability to perform any activities of daily living;

"(II) health status;

"(III) mental status;

"(IV) current living arrangements; and

"(V) use of formal and informal long-term care support systems.

If the health or mental condition of the policyholder is determined to be likely to change, the qualified case manager shall reassess such policyholder within a reasonable period of time after such initial assessment, as determined appropriate by the qualified case manager in consultation with the appropriate qualified insurer.

"(ii) CARE PLAN DEVELOPMENT.—After the qualified case manager conducts the benefits assessment of the policyholder, the case manager shall develop a written care plan that is in accordance with the care and service needs of the policyholder and the availability of the appropriate care and services. The care plan shall identify—

"(I) the long-term care problems and needs of the policyholder;

"(II) the mix of formal and informal services and support systems that are available to meet the long-term care and service needs of the policyholder;

"(III) the goals for the policyholder; and

"(IV) the appropriate services necessary to meet such needs.

"(iii) CARE PLAN IMPLEMENTATION.—After a face-to-face interview with the policyholder and such policyholder's spouse or primary caregiver, where appropriate, the qualified case manager, in consultation with the policyholder's primary medical care provider, shall arrange for the provision of appropriate care and services. The qualified case manager shall assist in making the necessary service arrangements for the implementation of the care plan to the extent that the policyholder consents.

"(iv) CARE PLAN MONITORING.—The qualified case manager shall monitor the delivery of services to the policyholder, the quality of care provided, and the status of the policyholder. Periodic reassessments of the status and needs of the policyholder, and revisions of the care plan, shall be made by the qualified case manager as appropriate. Such reassessments shall be conducted not less than every 6 months. If the policyholder is no longer eligible for bene-

fits as a result of improved health conditions, death, or depletion of the maximum lifetime benefit, the qualified case manager, in consultation with the policyholder's primary medical care provider, shall discharge the case.

"(b) MAXIMUM DAILY AND LIFETIME BENEFITS.—

"(1) MAXIMUM DAILY BENEFITS.—

"(A) IN GENERAL.—Each qualified long-term care insurance policy shall provide for a maximum daily benefit payable for nursing facility services and a maximum daily benefit payable for home and community based services.

"(B) INCREASES IN MAXIMUM DAILY BENEFITS.—The maximum daily benefits under subparagraph (A) shall be increased at a compounded rate of 5 percent per year.

"(2) MAXIMUM LIFETIME BENEFIT.—

"(A) IN GENERAL.—Each qualified long-term care insurance policy shall offer a maximum lifetime benefit equal to the amount determined under subparagraph (B). The maximum lifetime benefit shall be increased at a compounded rate of 5 percent per year.

"(B) AMOUNT OF MAXIMUM LIFETIME BENEFIT.—The amount determined under this subparagraph shall be an amount equal to—

"(i) for qualified long-term care insurance policies issued during fiscal year 1995, an amount equal to $60,000 increased or decreased by the percentage by which the cost of furnishing services under such policies in the State is greater or lesser than median cost of furnishing such services in all States, as determined by the Secretary; and

"(ii) for qualified long-term care insurance policies issued during fiscal year 1996 and succeeding fiscal years, an amount equal to the amount determined under this subparagraph for the preceding fiscal year updated by the estimated percentage change in the Consumer Price Index from the midpoint of the preceding fiscal year through the midpoint of such succeeding fiscal year, with appropriate adjustments to reflect previous underestimations or overestimations in the estimated percentage change in that index.

"(C) USE.—The maximum lifetime benefit under subparagraph (A) may be used to pay for case management services, nursing facility services, and home and community based services.

"(D) TERM OF POLICY.—Coverage under a qualified long-term care insurance policy shall continue for the life of the policyholder or until the maximum lifetime benefit has been depleted.

"PREMIUMS UNDER QUALIFIED LONG-TERM CARE INSURANCE POLICIES

"SEC. 2136. (a) AMOUNT.—

"(1) IN GENERAL.—The amount of the premium to be charged by a qualified insurer for a qualified long-term care insurance policy shall be determined by each qualified insurer, subject to State insurance regulations.

"(2) PREMIUM RATE STRUCTURE.—The State insurance commission shall ensure that the premium rate structure applicable to a qualified long-term care insurance policy remains level throughout the life of the policy.

"(3) REDUCED PREMIUMS.—

"(A) IN GENERAL.—A policyholder shall be eligible for reduced premiums under the policyholder's qualified long-term care insurance pol-

icy if the policyholder's income during any period determined appropriate by the State Standards and Performance Organization does not equal or exceed 400 percent of the income official poverty line for such period. Such reduced premiums shall remain in effect for a period determined appropriate by such Organization.

"(B) DETERMINATION OF AMOUNT OF REDUCTION.—The amount of the premium reduction under subparagraph (A) shall be based on a sliding scale established by the State Standards and Performance Organization. The maximum amount of a premium reduction shall be an amount equal to 75 percent of the premium amount and shall apply in the case of a policyholder with an income at or below 100 percent of the income official poverty line.

"(b) CESSATION OF PREMIUM PAYMENTS.—A qualified long-term care insurance policy shall provide that, after the expiration of a 30-consecutive day period during which nursing facility service or home and community based service benefits are paid under the policy, the policyholder shall no longer be required to pay the premium due under such policy if the policyholder remains continuously

eligible for and receives benefits for which reimbursement is available under the policy.

"(c) REVIEW OF PREMIUM RATE STRUCTURES.—

"(1) IN GENERAL.—The State insurance commission, at least once during each consecutive 3-year period, shall review the premium rate structure applicable to a qualified long-term care insurance policy for the purpose of determining whether to permit adjustments to be made by a qualified insurer to such premium rate structure.

"(2) APPROVALS OF PREMIUM RATE STRUCTURE CHANGE.—

"(A) APPROVAL REQUIRED.—A qualified insurer may not adjust the premium rate structure for a qualified long-term care insurance policy unless such adjustment is approved by the State insurance commission.

"(B) REVIEW UNDER PART A.—For purposes of determining whether an adjustment in a premium rate structure should be approved under subparagraph (A), the State insurance commission, at least once during each consecutive 3-year period, shall review the payment rates applicable to services provided under part A of this title. The State insurance commission

may approve a change in the premium rate structure applicable to a qualified long-term care insurance policy for qualified insurers if the rate of increase in payment rates for services provided under part A differs significantly from the rate of increase for maximum daily benefit amounts under section 2135(b)(1)(B).

"(C) ADDITIONAL REQUIREMENTS FOR GROUP POLICY PREMIUM RATE STRUCTURE ADJUSTMENTS.—Premium rate structure adjustments for group qualified long-term care insurance policies shall be permitted under this section only—

"(i) on a class basis;

"(ii) if such adjustment is applied to all individuals in the particular enrollment class; and

"(iii) if such adjustment meets all appropriate State requirements for premium rate structure adjustments required under applicable State law.

"(d) POLICY LAPSES FOR FAILURE TO PAY PREMIUM.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a qualified long-term care insurance pol-

icy shall provide that if a scheduled premium for such policy is not paid, the policy will not lapse prior to the expiration of a 60-day period beginning on the date on which such premium is due for failure to pay premiums and such policy shall remain in force during such 60-day period.

"(2) REINSTATEMENT.—A qualified insurer may elect to reinstate a qualified long-term care insurance policy that has lapsed. The acceptance of a premium payment by a qualified insurer, after the expiration of the period referred to in paragraph (1), shall constitute a reinstatement of the policy to which such premium is applied and no application for such reinstatement shall be required. No underwriting or new age-related premiums shall be permitted in the case of such reinstatements.

"PORTABILITY REQUIREMENTS

"SEC. 2137. (a) GROUP POLICIES.—In the case of a qualified long-term care insurance policy that is offered in the form of a group insurance policy, the qualified insurer providing such policy shall ensure that the policy includes a continuation and conversion of coverage provision that permits a policyholder who is no longer part of the group to make direct premium payments to the insurer, as provided under this part, to keep such policy from lapsing. For the 18-month period beginning on the date a pol-

icyholder leaves a group, the premium amount required to be paid by such policyholder shall be the amount in effect on such date.

"(b) POLICYHOLDERS WHO CHANGE STATE OF RESIDENCE.—

"(1) IN GENERAL.—If a policyholder residing in a State has purchased a qualified long-term care insurance policy under this part and such policyholder at a later date changes the policyholder's residence to another State, such policyholder shall convert to a qualified long-term care insurance policy offered by a qualified insurer in the State of new residence as provided in this part.

"(2) RESPONSIBILITIES OF STATE OF NEW RESIDENCE.—In the case of a policyholder who converts the policyholder's qualified long-term care insurance policy under paragraph (1), the State of new residence shall—

"(A) upon the application of the policyholder, accept such policyholder into the Secure Choice Insurance Program of the State; or

"(B) in the case of a policyholder who is receiving services under the policy at the time of the change in residence, reimburse the quali-

fied insurer for the benefit subsidy amount under section 2138(b)(2).

"PAYMENTS TO QUALIFIED PROVIDERS; BENEFIT SUBSIDIES

"SEC. 2138. (a) PAYMENTS TO QUALIFIED PROVIDERS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a qualified insurer shall pay a qualified provider for the costs of furnishing services covered under a qualified long-term care insurance policy.

"(2) LIMITATIONS.—

"(A) MAXIMUM DAILY BENEFITS.—A qualified insurer shall not be liable for costs of furnishing services described in section 2135(a)(1) under a qualified long-term care insurance policy which are in excess of the maximum daily benefits described in section 2135(b)(1).

"(B) MAXIMUM LIFETIME BENEFIT.—A qualified insurer shall not be liable for costs of furnishing services described in section 2135(a)(1) under a qualified long-term care insurance policy which are in excess of the maximum lifetime benefit described in section 2135(b)(2).

"(b) REIMBURSEMENT BY STATE TO QUALIFIED INSURER.—

"(1) IN GENERAL.—Upon receipt of a claim from a qualified insurer in connection with payments described in subsection (a)(1), a State shall pay to the qualified insurer the benefit subsidy amount determined in accordance with paragraph (2). A State shall make payment under a claim submitted by a qualified insurer under this paragraph not later than 30 days after the State receives such claim.

"(2) BENEFIT SUBSIDY AMOUNT.—For purposes of paragraph (1), the benefit subsidy amount for a payment under subsection (a)(1) is an amount equal to the amount of such payment less the amount for which the qualified insurer is liable as determined under paragraph (3) and the amount for which the policyholder is liable as determined under paragraph (4).

"(3) LIABILITY OF QUALIFIED INSURER.—

"(A) IN GENERAL.—A qualified insurer shall be liable for a portion of the amount paid under subsection (a)(1) for any services equal to the sum of—

"(i) the additional benefit amount determined under subparagraph (B); and

"(ii) the premium related amount determined under subparagraph (C).

"(B) ADDITIONAL BENEFIT AMOUNT.—The additional benefit amount determined under this subparagraph is an amount equal to the portion of the amount paid under subsection (a)(1) for any services attributable to payments for benefits that are in addition to the benefits required under section 2135(a)(1).

"(C) PREMIUM RELATED AMOUNT.—

"(i) IN GENERAL.—The premium related amount determined under this subparagraph is an amount equal to the product of the amount paid under subsection (a)(1) for the services and the ratio of the actual premium payment amount determined under clause (ii) to the estimated premium payment amount determined under clause (iii).

"(ii) ACTUAL PREMIUM PAYMENT AMOUNT.—The actual premium payment amount determined under this clause is an amount equal to the accumulated value of the actual premiums paid by a policyholder under a qualified long-term care insurance

policy with respect to the benefits required under section 2135(a)(1).

"(iii) ESTIMATED PREMIUM PAYMENT AMOUNT.—The estimated premium payment amount determined under this clause is an amount equal to the estimated accumulated value of the premiums that would have been paid by a policyholder under a qualified long-term care insurance policy with respect to the benefits required under section 2135(a)(1) if no premium reductions occurred with respect to such policy under section 2136(a)(3). The estimated premium payment amount under this clause shall be determined using the same assumptions and methodologies used to determine the actual premium payment amount under clause (ii).

"(4) LIABILITY OF POLICYHOLDER.—

"(A) IN GENERAL.—A policyholder shall be liable for a portion of the amount paid under subsection (a)(1) for any services equal to the excess amount determined under subparagraph (B).

"(B) EXCESS AMOUNT.—

"(i) IN GENERAL.—The excess amount determined under this subparagraph for any services is the amount by which—

"(I) the amount paid under subsection (a)(1), less the additional benefit amount determined under paragraph (3)(B) and the premium related amount determined under paragraph (3)(C), exceeds

"(II) the limitation amount determined under clause (ii).

"(ii) LIMITATION AMOUNT.—The limitation amount determined under this clause for any services is an amount equal to the product of—

"(I) the limited cost of services amount determined under clause (iii) for the services; and

"(II) the number of days for which the services were provided.

"(iii) LIMITED COST OF SERVICES AMOUNT.—The limited cost of services amount determined under this clause is—

"(I) in the case of nursing facility services, the amount that is equal to the 80th percentile nursing facility resident per diem rate paid under part A in the State on the date an individual becomes eligible to have payments made on such individual's behalf under a qualified long-term care insurance policy, or

"(II) in the case of home and community based services, the amount that is equal to 60 percent of the amount determined under subclause (I).

"FEDERAL CONTRIBUTION

"SEC. 2139. The Secretary shall pay to each State for each quarter beginning with the first quarter after the date of the enactment of this part an amount that is equal to the sum of—

"(1) an amount equal to the product of the Federal long-term care assistance percentage for the State under part A and the State's expenditures for benefit subsidies under section 2138(b) for such quarter; and

"(2) an amount equal to 75 percent of the amount expended during such quarter as the Sec-

retary determines to be necessary for the proper and efficient administration of the State plan.

"RESOURCE RULES

"SEC. 2140. (a) IN GENERAL.—The minimum resource requirement under part A that applies to a policyholder shall be increased by an amount equal to $5,000 for each year during which a qualified long-term care insurance policy is in effect, up to $100,000 above such minimum resource requirement.

"(b) ELIGIBILITY UNDER PART A.—A policyholder shall not be eligible for services under part A until the policyholder—

"(1) has exhausted the maximum lifetime benefit under a qualified long-term care insurance policy purchased under this part; and

"(2) meets the eligibility requirements under part A (except that with respect to the minimum resource requirement, the provisions of subsection (a) shall be substituted for the provisions under part A).

"STANDARDS AND PERFORMANCE ORGANIZATIONS

"SEC. 2141. (a) REQUIREMENT.—Each State shall establish a Standards and Performance Organization in accordance with this section.

"(b) ESTABLISHMENT.—In establishing the Standards and Performance Organization under subsection (a), the chief executive officer of the State shall consult with

representatives of appropriate State agencies, as identified by the chief executive officer. The chief executive officer of the State may create a new entity to operate as the Standards and Performance Organization within the State or may designate an existing State entity as such Organization. The chief executive officer shall appoint representatives of appropriate State agencies to serve as the board of directors of the Standards and Performance Organization.

"(c) FUNCTIONS.—The Standards and Performance Organization shall—

"(1) ensure that the qualified long-term care insurance policies under this part cover at least the care and services described in section 2135(a)(1);

"(2) ensure that qualified insurers comply with the insurance laws and regulations established by the State;

"(3) ensure that information concerning the program established under this part is made available to individuals within the State in accordance with section 2142;

"(4) ensure the quality and appropriateness of the case management services provided to policyholders under any qualified long-term care insurance policy;

"(5) ensure that qualified providers meet standards established by the State;

"(6) develop and submit to the State insurance commission standards applicable to qualified insurers regarding rejection rates for underwriting;

"(7) on an annual basis, verify the income of the policyholders and determine eligibility for any premium reductions as provided for under section 2136(a)(3);

"(8) provide written notice to insurers of any changes in the income of policyholders which result in such policyholders being eligible for a premium reduction;

"(9) carry out the educational program implemented under section 2142 in the State;

"(10) establish appropriate appeals procedures for the appeals described in subsection (d); and

"(12) carry out such other functions as the Secretary or the chief executive officer of the State may require.

"(d) APPEALS OF CERTAIN DENIALS.—A policyholder may appeal to the Standards and Performance Organization any decision of a qualified insurer to deny such policyholder coverage, to refuse to pay a claim or to refuse to provide the policyholder with access to benefits.

"EDUCATIONAL PROGRAM

"SEC. 2142. (a) IN GENERAL.—The Standards and Performance Organization of the State shall implement a comprehensive public information and education program that shall be targeted to individuals age 45 and above but which shall attempt to educate the general public as a whole concerning the need for long-term care insurance.

"(b) REQUIREMENTS.—The public information and education program implemented in a State under subsection (a) shall include—

"(1) the development and distribution of brochures and other written materials that describe—

"(A) the growing elderly population of the United States and the State, and its anticipated impact on financial resources and available long-term care services;

"(B) the current methods of financing long-term care (including Government programs);

"(C) the need for long-term care insurance;

"(D) the eligibility requirements for participation in the program implemented under this part;

"(E) the basic minimum benefit package, limitations, and qualifications for qualified long-term care insurance policies; and

"(F) the appropriateness of purchasing qualified long-term care insurance policies;

"(2) the convening of educational forums dealing with the program implemented under the State plan throughout the State;

"(3) mass media advertisements;

"(4) programs to assist employers in providing information to their employees concerning the program established in the State under this part; and

"(5) other public information and education strategies that are determined appropriate by the Standards and Performance Organization.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on October 1, 1994.

SEC. 102. CONTINUING ELIGIBILITY OF INDIVIDUALS ELIGIBLE FOR LONG-TERM CARE BENEFITS UNDER TITLE XIX UNDER NEW TITLE XXI.

The Secretary of Health and Human Services shall provide that individuals eligible for services provided under title XIX of the Social Security Act which effective upon the date of enactment of this Act are provided under title XXI of the Social Security Act shall continue to be eligible

to receive such services in the same amount, duration, and scope as such individuals would have been eligible to receive but for the provisions of this Act.

SEC. 103. REPEAL OF LONG-TERM CARE PROVISIONS IN TITLE XIX OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1901 et seq.) is amended—

(1) in section 1902 by repealing subsection (a)(13)(F); and

(2) by repealing section 1929.

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1994.

SEC. 104. STUDY OF FORMULA FOR PAYMENT OF LONG-TERM CARE SERVICES.

The Comptroller General shall study, and report to Congress on such study no later than 1 year after the date of enactment of this Act, on the appropriateness and adequacy of using the Federal medical assistance percentage utilized under title XIX of the Social Security Act for payment of services provided under title XXI of the Social Security Act. Such study shall consider the following factors in determining a payment formula:

(1) The average income of the elderly in the State compared to the average income of the elderly in the Nation.

(2) The percent of elderly in the State under the income official poverty line (as determined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) compared to the percent of elderly under such income line in the Nation.

(3) The percentage of elderly in the State with income above the income official poverty line (as described in paragraph (2)) but below 240 percent of such income line (and various intervals in between) compared to national statistics.

(4) The percent of elderly over 75 years of age in the State compared to the percent of elderly over 75 in the Nation.

(5) Other appropriate issues, including measures of State fiscal capacity.

SEC. 105. LONG-TERM CARE DATA COLLECTION SYSTEM.

(a) IN GENERAL.—The Secretary of Health and Human Services, in collaboration with the National Association of Insurance Commissioners, shall establish a data collection system for public and private long-term care services to be utilized—

(1) to assess the costs of long-term care services and predict the future costs of such services;

(2) to determine the types of long-term care services provided and predict the future need for such services;

(3) to determine how long-term care relates to the medical problems experienced by the elderly; and

(4) in other matters determined appropriate by such Secretary.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report that shall include—

(1) a description of the data collection system described in subsection (a);

(2) a description of the types of data collected using such system and an analysis of such data;

(3) a description of the sources of the data;

(4) a description of the manner in which the data was collected; and

(5) any other information determined appropriate by such Secretary.

SEC. 106. CREATION OF NEW ADMINISTRATIVE UNIT FOR LONG-TERM CARE PROGRAM.

The Secretary of Health and Human Services shall establish a new organizational unit to administer the new long-term care assistance program established by this Act.

SEC. 107. SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.

The Secretary of Health and Human Services shall, within 90 days of the date of enactment of this Act, submit to the appropriate committees of the Congress, a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

TITLE II—LONG-TERM CARE TAX PROVISIONS

SEC. 200. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

PART I—GENERAL PROVISIONS

SEC. 201. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in subsection (f)), or".

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to deduction for medical, dental, etc. expenses), as amended by section 13131(d)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended by adding at the end the following new subsection:

"(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, rehabilitative, and maintenance (including personal care) services—

"(A) which are required by an individual during any period during which such individual is a functionally impaired individual,

"(B) which have as their primary purpose the provision of needed assistance with 1 or more activities of daily living which a functionally impaired individual is certified as being unable to perform under paragraph (2)(A), and

"(C) which are provided pursuant to a continuing plan of care prescribed by a licensed health care practitioner (other than a relative of such individual).

"(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

"(A) IN GENERAL.—The term 'functionally impaired individual' means any individual who is certified by a licensed health care practitioner (other than a relative of such individual) as being unable to perform, without substantial assistance from another individual (including assistance involving verbal reminding, physical cueing, or substantial supervision), at least 3 activities of daily living described in paragraph (3).

"(B) SPECIAL RULE FOR HOME HEALTH CARE SERVICES.—In the case of services which are provided during any period during which an individual is residing within the individual's home (whether or not the services are provided

within the home), subparagraph (A) shall be applied by substituting '2' for '3'. For purposes of this subparagraph, a nursing home or similar facility shall not be treated as a home.

"(3) ACTIVITIES OF DAILY LIVING.—

"(A) IN GENERAL.—Each of the following is an activity of daily living:

"(i) Eating.

"(ii) Transferring.

"(iii) Toileting.

"(iv) Dressing.

"(v) Bathing.

"(B) REQUIREMENT ON THE SECRETARY.—For purposes of this section, the Secretary shall utilize the definitions and standards for measuring the ability to perform the activities of daily living described in subparagraph (A) developed by the Secretary of Health and Human Services under section 2115(d)(4)(B) of the Social Security Act.

"(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means—

"(A) a physician or registered professional nurse,

"(B) a qualified community care case manager (as defined in section 2115(k) of the Social Security Act), or

"(C) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

"(5) RELATIVE.—The term 'relative' means an individual bearing a relationship to another individual which is described in paragraphs (1) through (8) of section 152(a)."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

"(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged)—

"(i) covering medical care referred to in subparagraphs (A) and (B), or

"(ii) covering medical care referred to in subparagraph (C), but only if such insurance is provided under a qualified long-

term care insurance contract (as defined in section 7702B(b))."

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking "subparagraphs (A) and (B)" in the matter preceding subparagraph (A), and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

SEC. 202. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

"(a) GENERAL RULE.—For purposes of this title—

"(1) a qualified long-term care insurance contract shall be treated as an accident or health insurance contract,

"(2) any plan of an employer providing coverage of qualified long-term care services shall be

treated as an accident or health plan with respect to such services,

"(3) amounts received under such a contract or plan with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

"(4) payments described in subsection (b)(5) shall be treated as payments made with respect to qualified long-term care services.

"(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—

"(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care insurance contract' means any insurance contract if—

"(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

"(B) such contract meets the requirements of paragraphs (2), (3), and (4), and

"(C) such contract is issued by a qualified issuer.

"(2) PREMIUM REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to a contract if such contract provides that—

"(i) premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life of the contract (or, if shorter, 20 years), and

"(ii) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

A contract shall not be treated as failing to meet the requirements of clause (i) solely by reason of a provision providing for a waiver of premiums if the policyholder becomes a functionally impaired individual.

"(B) REFUNDS UPON DEATH OR COMPLETE SURRENDER OR CANCELLATION.—Subparagraph (A)(ii) shall not apply to any refund on the death of the policyholder, or on any complete surrender or cancellation of the contract, if, under the contract, the amount refunded may not exceed the amount of the premiums paid under the contract. For purposes of this title, any refund described in the preceding sen-

tence shall be includible in gross income to the extent that any deduction or exclusion was allowed with respect to the refund.

"(3) BORROWING, PLEDGING, OR ASSIGNING PROHIBITED.—The requirements of this paragraph are met with respect to a contract if such contract provides that no money may be borrowed under such contract and that such contract (or any portion thereof) may not be assigned or pledged as collateral for a loan.

"(4) PROHIBITION OF DUPLICATE PAYMENT.—The requirements of this paragraph are met with respect to a contract if such contract does not cover expenses incurred to the extent that such expenses are reimbursable under title XVIII of the Social Security Act.

"(5) PER DIEM AND OTHER PERIODIC PAYMENTS PERMITTED.—

"(A) IN GENERAL.—For purposes of subsection (a)(4), and except as provided in subparagraph (B), payments are described in this paragraph for any calendar year if, under the contract, such payments are made to (or on behalf of) a functionally impaired individual on a per diem or other periodic basis without regard

to the expenses incurred or services rendered during the period to which the payments relate.

"(B) EXCEPTION WHERE AGGREGATE PAYMENTS EXCEED LIMIT.—If the aggregate payments under the contract for any period (whether on a periodic basis or otherwise) exceed the dollar amount in effect for such period—

"(i) subparagraph (A) shall not apply for such period, and

"(ii) the requirements of paragraph (1)(A) shall be met only if such payments are made with respect to qualified long-term care services provided during such period.

"(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount in the case of payments on another periodic basis).

"(D) ADJUSTMENTS FOR INCREASED COSTS.—

"(i) IN GENERAL.—In the case of any calendar year after 1993, the dollar amount in effect under subparagraph (C)

for any period occurring during such calendar year shall be equal to the sum of—

"(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

"(II) the applicable percentage of the amount under subclause (I).

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means, with respect to any calendar year, the greater of—

"(I) 5 percent, or

"(II) the cost-of-living adjustment for such calendar year.

"(iii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (ii), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iv) for the preceding calendar year exceeds such index for the second preceding calendar year. In the case of any calendar year beginning before 1995, this clause shall be applied by substituting the Consumer Price Index (as

defined in section 1(f)(5)) for the cost index under clause (iv).

"(iv) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1995, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

"(E) AGGREGATION RULE.—For purposes of this paragraph, all contracts issued with respect to the same policyholder by the same company shall be treated as 1 contract.

"(c) QUALIFIED ISSUER.—For purposes of this section, the term 'qualified issuer' means any person which at the time of the issuance of a long-term care insurance contract—

"(1) uses a one year preliminary term method for setting up reserves, and

"(2) maintains a capital ratio equal to not less than 25 percent of long-term care insurance premium receivables.

"(d) SPECIAL RULES FOR TAX TREATMENT OF POLICYHOLDERS.—For purposes of this title, solely with respect to the policyholder under any qualified long-term care insurance contract—

"(1) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—If the aggregate payments under all qualified long-term care insurance contracts with respect to a policyholder for any period (whether on a periodic basis or otherwise) exceed the dollar amount in effect for such period under subsection (b)(5)—

"(A) subsection (b)(5) shall not apply for such period, and

"(B) such payments shall be treated as made for qualified long-term care services only if made with respect to such services provided during such period.

"(2) ASSIGNMENT OR PLEDGE.—Such contract shall not be treated as a qualified long-term care insurance contract during any period on or after the date on which the contract (or any portion thereof) is assigned or pledged as collateral for a loan.

"(e) TREATMENT OF COVERAGE AS PART OF A LIFE INSURANCE CONTRACT.—

"(1) IN GENERAL.—Except as provided in regulations, in the case of coverage of qualified long-term

care services provided as part of a life insurance contract, the requirements of this section shall apply as if the portion of the contract providing such coverage was a separate contract.

"(2) PORTION DEFINED.—For purposes of paragraph (1), the term 'portion' means only the terms and benefits under a life insurance contract (whether provided by a rider to, addendum on, or other provision of, such contract) that are in addition to the terms and benefits under the contract without regard to the coverage of qualified long-term care services.

"(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' has the meaning given such term by section 213(f).

"(2) RECERTIFICATION.—If an individual has been certified as a functionally impaired individual under section 213(f)(2)(A), services shall not be treated as qualified long-term care services with respect to the individual unless such individual is recertified no less frequently than annually as a functionally impaired individual in the same manner as under such section, except that such

recertification may be made by any licensed health care practitioner (as defined in section 213(f)(4)), other than a relative (as defined by section 213(f)(5)) of such individual.

"(g) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Section 4980B shall not apply to—

"(1) qualified long-term care insurance contracts, or

"(2) plans described in subsection (a)(2).

"(h) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing qualified long-term care services under a life insurance contract."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

"Sec. 7702B. Treatment of long-term care insurance or plans."

SEC. 203. EFFECTIVE DATES.

(a) SECTION 201.—The amendments made by section 201 shall apply to taxable years beginning after the date of the enactment of this Act.

(b) SECTION 202.—The amendments made by section 202 shall apply to contracts issued after the date of the enactment of this Act.

(c) TRANSITION RULE.—If, after the date of the enactment of this Act and before January 1, 1996, a contract providing coverage for services which are similar to qualified long-term care services (as defined in section 213(f) of the Internal Revenue Code of 1986) and issued on or before January 1, 1994, is exchanged for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), such exchange shall be treated as an exchange to which section 1035 of such Code applies.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 211. POLICY REQUIREMENTS.

(a) IN GENERAL.—Section 7702B (as added by section 202) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

"(h) CONSUMER PROTECTION PROVISIONS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

"(A) the requirements of the model regulation and model Act described in paragraph (2),

"(B) the disclosure requirement of paragraph (3),

"(C) the requirements relating to nonforfeitability under paragraph (4), and

"(D) the requirements relating to rate stabilization under paragraph (5).

"(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

"(i) MODEL REGULATION.—The following requirements of the model regulation:

"(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

"(II) Section 7B (relating to prohibitions on limitations and exclusions).

"(III) Section 7C (relating to extension of benefits).

"(IV) Section 7D (relating to continuation or conversion of coverage).

"(V) Section 7E (relating to discontinuance and replacement of policies).

"(VI) Section 8 (relating to unintentional lapse).

"(VII) Section 9 (relating to disclosure), other than section 9F thereof.

"(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

"(IX) Section 11 (relating to minimum standards).

"(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

"(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(ii) MODEL ACT.—The following requirements of the model Act:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(B) DEFINITIONS.—For purposes of this paragraph—

"(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

"(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(3) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to

any policy if such policy meets the requirements of section 4980C(e)(1).

"(4) NONFORFEITURE REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision.

"(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

"(i) The nonforfeiture provision shall be appropriately captioned.

"(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

"(iii) The nonforfeiture provision shall provide at least one of the following:

"(I) Reduced paid-up insurance.

"(II) Extended term insurance.

"(III) Shortened benefit period.

"(IV) Other similar offerings approved by the Secretary.

"(5) RATE STABILIZATION.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy, including any group master policy, if—

"(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

"(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

"(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

"(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

"(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

"(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, rate increases under such policy shall not exceed 10 percent in any 12-month period.

"(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

"(i) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits which maintains the premium rate at the rate in effect

on the day before the effective date of the rate increase.

"(ii) INCREASES OF MORE THAN 50 PERCENT.—

"(I) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

"(aa) in the case of a group master long-term care insurance policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase; and

"(bb) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues

such policy for a period of 2 years from the effective date of such premium increase.

"(II) APPLICABILITY.—Subclause (I) shall apply to any issuer of long-term care insurance policies or any other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

"(C) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or waive any of the requirements under this paragraph if—

"(i) such requirements will adversely affect an issuer's solvency;

"(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements;

"(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions;

"(iv) judicial interpretation of a policy's benefit features results in unintended claim liabilities; or

"(v) in the case of a purchase or other acquisition of long-term care insurance policies of an issuer or other person, the continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interests of individual consumers.

"(6) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(f).".

(b) CONFORMING AMENDMENT.—Section 7702B(b)(1)(B) (as added by section 202) is amended by inserting "and of subsection (h)" after "and (4)".

SEC. 212. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-TERM CARE INSURANCE POLICIES.

"(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection

(c), (d), or (e) a tax in the amount determined under subsection (b).

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c), (d), or (e) are not met with respect to each long-term care insurance policy.

"(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

"(c) PROHIBITION OF SALE OR ISSUANCE TO BENEFICIARIES UNDER PART A OF TITLE XXI OF THE SOCIAL SECURITY ACT.—The requirement of this subsection is met if a person does not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under part A of title XXI of the Social Security Act.

"(d) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection are as follows:

"(1) REQUIREMENTS OF MODEL PROVISIONS.—

"(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

"(i) Section 13 (relating to application forms and replacement coverage).

"(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expended as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable pre-existing condition.

"(iii) Section 20 (relating to filing requirements for marketing).

"(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than section 21C(1) and 21C(6) thereof, except that—

"(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insur-

ance policy, misrepresent a material fact; and

"(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

"(v) Section 22 (relating to appropriateness of recommended purchase).

"(vi) Section 24 (relating to standard format outline of coverage).

"(vii) Section 25 (relating to requirement to deliver shopper's guide).

"(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).

"(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

"(A) provide a written explanation of the reasons for the denial, and

"(B) make available all information directly relating to such denial.

"(e) DISCLOSURE.—The requirements of this subsection are met if either of the following statements, whichever is applicable, is prominently displayed on the front page of any long-term care insurance policy and in the outline of coverage required under subsection (d)(1)(B)(ii):

"(1) A statement that: 'This policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

"(2) A statement that: 'This policy is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

"(f) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance."

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

"Sec. 4980C. Failure to meet requirements for long-term care insurance policies."

SEC. 213. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this title shall be construed as preventing a State from applying standards that provide greater protection of policyholders of long-term care insurance policies (as defined in section 4980C(f) of the Internal Revenue Code of 1986).

SEC. 214. UNIFORM LANGUAGE AND DEFINITIONS.

(a) IN GENERAL.—The National Association of Insurance Commissioners shall not later than January 1, 1995, promulgate standards for the use of uniform language and definitions in long-term care insurance policies (as defined in section 4980C(f) of the Internal Revenue Code of 1986).

(b) VARIATIONS.—Standards under subsection (a) may permit the use of nonuniform language to the extent required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

SEC. 215. EFFECTIVE DATES.

(a) SECTION 211.—The amendments made by section 211 shall apply to contracts issued after the date of the enactment of this Act, except that the provisions of section 203(c) of this Act shall apply to such contracts.

(b) SECTION 212.—The amendments made by section 212 shall apply to actions taken after December 31, 1993.

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